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SOCIAL SUPPORT, ATTRIBUTIONAL STYLE, AND SELF-BLAME IN CHILD SURVIVORS OF SEXUAL ABUSE

by

Linda R. Reinstein
B.A., McGill University, 1991

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ABSTRACT

This exploratory study was designed to gain some preliminary insight into the dynamic relationships among children's perceptions of the quality of their social support network, current attributional styles, and perceptions of self-blame related to their experiences of sexual abuse. Based on Hindman's (1989) model, it is proposed that children who have been sexually abused evaluate their victim status and assign self-blame according to perceptions of their relationships with both the offender and significant others. In this study, ten 8-17 year old female survivors of intrafamilial sexual abuse completed the Social Support Scale for Children and Adolescents (SSSC) (Harter, 1985), the Children's Attributional Style Questionnaire (KASTAN) (Seligman, Peterson, Kaslow, Tannenbaum, Alloy, & Abramson, 1984), and the Reflected Self-Parents measure of the Self Perception Inventory (SPI) (Soares & Soares, 1975). The participants' therapists provided ratings of the participants' degree of self-blame and social support related to the sexual abuse. These ratings were obtained using a modified version of the items from the Social Support and Self-Blame subscales of the Children's Impact of Traumatic Events Scale-Revised (CITES-R) (Wolfe & Gentile, 1991). Findings of the present study lend preliminary support to Hindman's (1989) model, in that participants who perceived higher levels of maternal support

tended to blame themselves less for the abuse and were found to have less negative attributional styles than participants who perceived lower levels of maternal support. Moreover, participants who perceived higher levels of social support coming from the offender tended to blame themselves more for the abuse and were found to have more negative attributional styles than those who perceived less social support coming from the offender. Research and treatment implications of the present study are discussed, as are directions for future research.

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CHAPTER I

INTRODUCTION

Although the exact prevalence rate of childhood sexual abuse seems to vary slightly across North American population studies, it represents a pervasive problem in society that cuts across culture, social class, and racial boundaries (Finkelhor & Baron, 1986). Findings from studies of the general population in North America indicate that prevalence rates of sexual victimization, ranging from fondling to intercourse, are 20% to 30% for females (Finkelhor, Hotaling, Lewis, & Smith, 1990; Russell, 1986; Wyatt, 1989), and 10% to 20% for males (Finkelhor et al., 1990; Finkelhor et al., 1986).

The psychological impact of sexual abuse in childhood has received a great deal of attention in recent years. Both the short and long-term effects of this abuse have been well documented in recent clinical literature (Bagley, 1991; Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992). Studies on short-term effects indicate that generally, children who have experienced sexual abuse tend to be more fearful, angry, aggressive, and exhibit more sexually inappropriate behaviour than non-abused control children (Finkelhor, 1990). As well, they manifest more anxiety than other children (Mannarino, Cohen, & Gregor, 1989; Finkelhor,

1990). A review of recent clinical and empirical studies presents a compilation of research that reveals that sexually abused children were more symptomatic in negative affective and somatic ways than their non-abused counterparts (Kendall-Tackett, Williams, & Finkelhor, 1993). Generally, these symptoms have included: nightmares, withdrawn behaviour, running away, general behaviour problems, and self-injurious behaviour.

Within adult populations, those who experienced child sexual abuse have been reported to exhibit a number of difficulties in their adult lives. Research has suggested that the majority of survivors of these experiences have psychological problems related to body image and/or eating disorders (McClelland, Mynors-Wallis, Fahy, & Treasure, 1991; Root & Fallon, 1988), depression (Bifuco, Brown, & Adler, 1991; Jehu, 1989; Rew, 1989), and anxiety (Gorcey, Santiago, & McCall-Perez, 1986). Furthermore, suicidal ideas and behaviour have been associated with a history of child sexual abuse (Beitchman et al., 1992). Other commonly reported long-term effects are difficulties with sexual functioning and intimacy within male-female relationships (Gorcey et al., 1986; Hindman, 1989; Wyatt & Newcomb, 1990).

An important issue borne out from such research is the significant variation that exists with regard to the frequency and severity of symptomatology displayed by certain survivors (Conte & Schuerman, 1987; Finkelhor, 1990;

Hindman, 1989). For instance, some researchers have attempted to account for variations in the symptomatology by examining characteristics of the abuse experience itself. The findings of studies reviewed by Kendall-Tackett et al. (1993), as well as those reviewed by Beitchman et al. (1991; 1992) indicated that a greater number of symptoms were evident in survivors whose molestations included a perpetrator who was close in relation to the victim, a higher frequency of sexual contact, a longer duration, and sexual acts that included oral, anal, or vaginal penetration.

Further, much of this research on factors that place the child at greater risk for negative long-term effects focus on factors that are relatively unchangeable (Conte & Schuerman, 1987). While these may be helpful in understanding the variation in impact of abuse and/or in identifying those at greater risk for subsequent impairment, they cannot be targets of therapeutic intervention since they are unchangeable. What is changeable, however, are the perceptions of the details surrounding the abuse. Indeed, the individual's psychological perception of the events associated with her/his molestation is becoming an area of clinical and research interest, particularly where such perceptions relate to attributions of responsibility and blame (Shapiro, Leifer, Martone, & Kassem, 1992).

Attribution of Blame

With respect to individual responses to victimization, attributional theory posits that the assignment of blame by the victim has immediate and long-term psychological implications and can be used to predict outcome, such that when a victim attributes the cause of the traumatic event to personal internal factors or characteristics, they are at greater risk for depression and anxiety (Janoff-Bulman, 1983). Much of the evidence for the maladaptive nature of self-blame comes from the literature documenting its association with depression. Beck (1972; Beck, Rush, Shaw, & Emery, 1979) found that compared to nondepressed psychiatric controls, depressed patients showed a much higher incidence of self-blame. Further evidence comes from research on depressive attribution. Some research projects have shown that depressed participants make more internal attributions for their failures, while nondepressed participants make more external attributions for negative events (Harvey, 1981; Kuiper, 1978; Seligman, Abramson, Semmel, & Von Baeyer, 1979).

Findings from a study examining risk factors for emotional distress in sexually abused girls may be interpreted to indirectly support an attributional model of self-blame leading to depressive symptoms and emotional distress (Mennen, 1993). Results from Mennen's (1993) study revealed that among girls who had been sexually abused by a

father or father figure, those whose abuse experiences were characterized by a lack of physical force or threat experienced significantly more distress than girls whose experiences included force. Conversely, when the perpetrator was not a father or father figure, the presence of force resulted in a greater likelihood of the child experiencing significantly higher levels of distress. The author posits that this interaction effect may be due to the fact that when the father is the abuser and no or little force is used, the daughter may feel that the abuse was under her control and hence would blame herself for its occurrence. On the other hand, when the father does use force during the abuse, the daughter may be more likely to interpret the abuse as a violation of a trusting and dependent relationship hence placing the responsibility for the abuse on the perpetrator. Thus, blaming the perpetrator may lessen the feelings of self-blame and guilt that can preface depression and low-self worth (Mennen, 1993). Similar results, regarding coercion and self-blame were found in another study by Conte and Shuerman (1987). These authors found more psychological impairment in sexually abused children who had received rewards from the perpetrator for complying with the abuse, compared to victims who did not receive reward. In attributional terms, this subtle coercion may result in internal attributions about the agent responsible for the abuse, while overt

coercion may cause external attributions to be formed.

Some of the research on attributional style, as it relates to the experience of child sexual abuse, is retrospective in nature. Research involving adult women survivors of childhood sexual abuse has shown a close relationship existing between their current level of psychological dysfunction and their present attributional style. For example, Gold (1986) found that women survivors were more likely to attribute current negative events to internal, stable, and global factors, as well as to their own character and behaviour. These same women tended to attribute the causes of good events to external factors. Such cognitive sequelae may contribute to or, alternatively, act as mediators of the negative symptomatology evident among adult survivors of child sexual abuse (Gold, 1986; Jehu, 1988).

It was not evident from Gold's (1986) study whether survivors' attributional styles developed prior to, or in response to their victimization experiences. Some research projects have attempted to address this issue by fleshing out the association between particular aspects of the child sexual abuse experience and current negative attributional styles of survivors (Hoagwood, 1990; Stern, 1989; Wyatt & Newcomb, 1990). For example, Stern (1989) found an association between characteristics of the abuse situation, such as bribery, a long duration, and threat of force, and a

particular attributional style that was characterized by internal, stable, and global patterns. Subsequently, Wyatt and Newcomb (1990) reported that internal attributions for the abuse (i.e., self-blame) in adulthood served as an important mediator variable to negative symptomatology. As such, self-blame mediated the impact of various aspects of the abuse situation, such as, the age at which the abuse occurred, duration of the abuse, and the psychological coercion. These findings foster a conceptual link between the current attributional style of the survivor and factors associated with the abuse situation that have been found to put victims at greater risk for subsequent problems.

Furthermore, Hoagwood (1990) had her sample of women respondents rate the degree of self-blame that they retrospectively remembered themselves as having in childhood. She found that women who remembered experiencing more self-blame in childhood also experienced greater current depression and lower self-esteem as adults. From one perspective, these findings suggest that the degree of self-blame that a child survivor experiences may be related to attributional styles and negative long-term effects of child sexual abuse that have been reported by adult survivors (Bagley, 1991).

Data explicitly delineating the relationship between attributional style and negative symptomatology in child survivor samples is empirically limited. One study,

conducted by Gentile, Wolfe, and Wolfe (1988), lends some support to the notion of this relationship between attributional style of child survivors and the severity of negative symptomatology. Results of this study suggest that children whose general attributional style tended to be self-deprecatory in nature (i.e., selectively attributing negative events to internal, global, and stable causes and pleasant events to external, specific, and unstable causes) were more likely to report higher scores on self-report measures of depression, such as the Children's Depression Inventory (Gentile et al., 1988). Results from another study revealed that children who engaged in self-blame, as reported by the participant's caretaker, exhibited significantly higher emotional distress than those participants who were not deemed to be blaming themselves (Shapiro et al., 1992). Further analyses revealed that self-blame was a significant predictor of participants' Internalizing scores on the Child Behaviour Checklist (Shapiro et al., 1992).

The relationship between self-blame and attributional style of survivors becomes more apparent when one considers how child survivors may come to understand their own abuse experiences. For instance, research on attributional development indicates that the ability to make inferences from outcomes to personal characteristics begins to develop at age five (Shapiro, 1989). As well, cognitive development

at this age is characterized by both dichotomous thinking and egocentricity. Thus, the young victim of sexual abuse may be caught in the so-called 'abuse dichotomy' (Briere, 1992). That is, in an attempt to make sense of the abuse experience, it is hypothesized that the child proceeds in a series of quasi-logical inferences. This series of inferences appears to proceed as follows:

> 1. I am being hurt, emotionally or physically, by a parent or other trusted adult.
> 2. Based on how I think about the world thus far, this injury can only be due to one of two things: Either I am bad or my parent is (the abuse dichotomy).
> 3. I have been taught by other adults, either at home or in school, that parents are always right, and always do things for your own good (any other alternative is very frightening). When they occasionally hurt you, it is for your own good, because you have been bad. This is called punishment.
> 4. Therefore, it must be my fault that I am being hurt, just as my parent says. This must be punishment. I must deserve this.
> 5. Therefore, I am as bad as whatever is done to me (the punishment must fit the crime: anything else suggests parental badness, which I have rejected). I am bad because I have been hurt. I have been hurt because I am bad.
> 6. I am hurt quite often, and/or quite deeply, therefore, I must be very bad.
>
> The power of the abuse dichotomy for the adolescent or adult abuse survivor resides, in part, in its self-perpetuating qualities: I was (and continue to be) hurt because of my badness, and evidence of my badness is that I have been (and continue to be) hurt. (Briere, 1992, p.28)

In some studies of attributional variables that sample child survivors, results have been mixed in terms of the degree to which children blame themselves for the abuse. Some researchers have found that abused children often blame

themselves and feel guilty about the abuse (DeYoung, 1982; Ney, Moore, McPhee, & Trought, 1986; Tsai & Wagner, 1978). For example, Ney et al. (1986) examined self-blame in a psychiatric sample of 5 to 12 year old children (n = 57) who had suffered some form of child abuse or neglect. They examined self-blame in relation to the extent of physical abuse, physical and emotional neglect, and sexual abuse. The relationship between abuse and self-blame was more clear than the relationship between neglect and self-blame. These researchers found that, across all forms of abuse, there was a strong relationship between "mild" or "severe", but not "moderately extensive" levels of mistreatment and self-assessed fault. Interestingly, sexually abused children in this study appeared to always blame themselves to some extent regardless of the frequency or severity of the abuse. In another study that investigated the influence of age on attributions of blame in child sexual abuse survivors, significant variation was found in the degree of self-blame across different age groups (Hunter, Goodwin, & Wilson, 1992). Specifically, 84% of 8-12 year old children of this study (n = 48) rated themselves "not at all" to blame for their victimization compared to 59% of 13-17 year old adolescents (n = 43) and 53% of the adults (n = 52) who were molested as children (18 and over). Furthermore, female participants in this study showed a negative relationship between the degree to which they blamed themselves for the

abuse and the degree to which they blamed the perpetrator (r = -.48, $p < .001$).

Measuring Self-Blame

The discrepancy between the results of these two studies may be due to methodological variations or flaws in measuring self-blame. It is difficult to assess the extent to which there was variation in the operational definitions between these studies since Ney et al. (1986) provided minimal information regarding the exact way in which self-blame was operationalized. In the Hunter et al. (1992) study, self-blame was operationalized by having each child rate his/her response to the following statement on a seven point Likert-type scale: "Rate how much you feel to blame for the molestation(s)", with "1" signifying "not at all" to "7" signifying "totally". Furthermore, Hunter et al. (1992) posited that the younger children's apparent lack of self-blame may be due to the extent to which children can reliably self-report blame. This is not likely the case since, as discussed before, the ability to make causal attributions to one's personal characteristics begins to develop at age five (Shapiro, 1989). One plausible explanation might be that the use of a single question as such was insensitive to the cognitive developmental level of the children in this age group. For instance, the use of more appropriate and familiar language in the wording of the

question may have yielded a different response. For instance, the term 'molestation' may not have been understood by the respondents, or they may have not had exposure to such a term in regard to their own sexual abuse. Furthermore, the use of multiple questions may be more appropriate for capturing the potentially multi-faceted construct of self-blame.

Another limitation of the operational definition of self-blame in the Hunter et al. (1992) study is the use of a seven point Likert type rating scheme to assess the degree of self-blame. Without concrete referents for each of the seven choices, the children may have been misconstruing the interval scale as a dichotomous choice of either one or seven, making little use of the gradations in between. If this was the case, then one would expect that the age differences in attribution of self-blame found in the Hunter et al. (1992) study would be attenuated if concrete referents were used for both the statement about self-blame and the rating scale itself. With such changes, younger children could be expected to report similar amounts of self-blame to those of the adolescents and adults who have a better understanding of the question and are better able to use the present rating scheme.

Another issue to be considered regarding the operationalization of self-blame is that of different facets or aspects of self-blame. Typically, self-blame has been

examined empirically as a uni-dimensional rather than a multi-dimensional construct. Based on attribution theory, Janoff-Bulman (1979) suggested that when victimization occurs, the basic assumption of perceived control over events in the victim's life is violated. In order to maintain this belief, the victim tends to use self-blaming attributions to gain personal control over future events. Thus, according to Janoff-Bulman, the ability to maintain this belief of personal control rests on the distinction between two types of self-blame, behavioural and characterological. Behavioural self-blame is control related, involves attributions to a modifiable source (i.e., one's behaviour), and is typically associated with a belief in the future avoidability of negative outcomes. Characterological self-blame, which is esteem related, involves attributions to a relatively non-modifiable source (e.g., one's character), and is associated with a belief in personal deservingness for past negative outcomes. None of the research on self-blame and sexual abuse seems to consider the possibility of a variety of different types of self-blaming attributions.

Factors Affecting Self-Blaming Attributions

As is suggested by the limited empirical evidence presented here, attributions regarding self-blame among survivors of child sexual abuse seem to mediate some of the

effects of the abuse. This is consistent with clinical experiences which imply that it is not the abuse alone, but the interpretation of the event that at least partially determines its impact upon survivors (Hindman, 1989; Shapiro, 1987). Hence, some data appear to support the increasing clinical attention that is being paid to the correction of faulty cognitions associated with self-blame, an area that is now becoming an integral component of most treatment programmes (Berliner, 1987; James, 1989; Shapiro, 1989).

Another issue to examine in this context is the multiple factors that affect attributions of self-blame. For instance, the findings of Wyatt and Newcomb (1990) suggest that factors such as age at the time the abuse began, duration of the abuse, and the use of psychological coercion are contributing antecedent factors when the victim is judging the degree to which s/he feels to blame for the abuse. Further, Hindman (1989), in her work dealing with a comprehensive assessment of trauma after sexual abuse, posits that in evaluating one's own victim status, the child victim's perceptions of their relationships with both the offender and significant others also become important factors. Figure 1 displays a schematic representation of this model.

In this model, the child's perceptions of these various relationships are used to guide attributions of self-blame

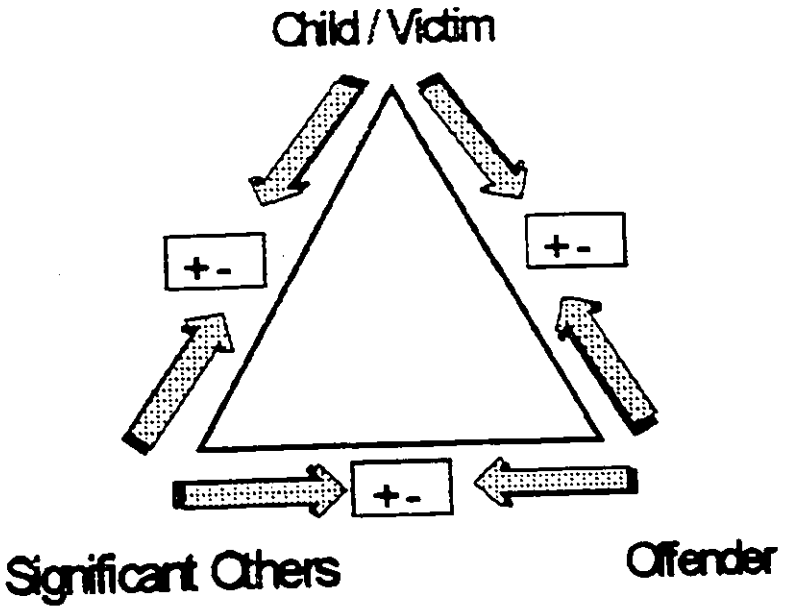

Figure 1. Schematic representation of Hindman's (1989) model

Theoretical Assumptions

1. The child/victim evaluates self-blame by assessing the quality of the relationships between her/himself and significant others, between her/himself and the offender, and between significant others and the offender.
2. The relationships are assumed to be evaluated as reciprocal, that is, from the child/victim's perspective, relationships are evaluated in terms of how the victim feels toward the other and how the victim feels the other perceives the relationship.
3. Each side of the relationship triangle is evaluated as positive or negative. The most optimal situation is represented by a configuration of a positive evaluation of the victim's relationships with the significant others and negative evaluations of the victim-offender and significant others-offender relationships.

and the assignment of victim status accordingly. One important aspect of Hindman's conceptualization is that these relationships are reciprocal. That is, the child not only evaluates how s/he feels toward the other person but also evaluates how s/he feels they are perceived by the other person.

Significant others are defined as those people with whom the child expects or wishes to have positive and supportive relationships. This almost always includes the non-offending parent, and can include siblings, the legal system, and various members of the community, such as teachers and friends.

When examining the relationships between the child and significant others, Hindman's (1989) model leads to the prediction that if the child perceives relationships with significant others positively, that is, feels love, respect, and value toward them and also feels similarly valued, loved, and respected by them, the child will not attribute blame for the abuse to her/himself. However, if a negative perception of these relationships ensues, the child is likely to attribute more blame to the self. Furthermore, relationships with significant others that have a direct connection with the offender would seem to be of more significance to the child than those relationships with significant others who are not directly connected with the offender. For example, when the offender is the child's

father, the child's relationship with mother would seem more significant in the evaluation of self-blame than a relationship with a supportive teacher.

In evaluating the quality of the relationship with the offender, the child goes through a similar process with the same bidirectional characteristics. One could similarly expect, based on this model, that when the child victim loves, respects, and values the offender and feels that the offender loves, respects, and values her/him, attributions of self-blame would be quite prominent. Thus, the child in this situation may attempt to reconcile incongruent feelings about the abuse, which is often experienced by the child as disgusting, punitive, or confusing, at best, and positive feelings toward the offender by blaming her/himself for the abuse (DeYoung & Lowry, 1992).

A third component to Hindman's (1989) model involves the child's perceptions of the relationships among significant others and the offender. Here, the child evaluates how significant others perceive the offender, as well as how the offender perceives significant others and interacts with them. If these relationships are perceived as being positive, the child would be expected to attribute more self-blame than if s/he views their relationships as being poor.

The process of assigning blame for the sexual abuse, as described by this model, is conceptually supported by a more

general model of self-worth. According to Harter (1986), one major source of self-worth is the incorporation of perceptions of social support in the form of positive regard from significant others. Her research findings have revealed that perceived positive regard from parents and peers is highly related to self-worth (Harter, 1992). Moreover, in the statistical modelling of the determinants of global self-worth, Harter found that perceived social support from parents and peers directly accounted for a significant and unique portion of variance of global self-worth scores (Harter, 1986). These findings are consistent with literature indicating that not only is social support a critical determinant of self-esteem (Sroufe & Rutter, 1985) but that it acts as a buffer to the potentially detrimental effects of stress (Rutter, 1989).

Hence, in terms of this more general model of the development of self-worth, the child who has experienced sexual abuse would be gaining information about their self-worth through their perceptions of the social support they are receiving from various important people in their lives. Specifically, it may be hypothesized that the child who is integrating positive social support from non-offending important others would develop a greater sense of global self-worth than the child who is perceiving a lack of positive social support. Consistent with this conceptual base, Hindman's model seeks to address issues regarding

differential and combined influences of positive social support coming from both offending and non-offending significant others.

Importance of Social Support

Hindman's (1989) model is based on the assumption that the construct of social support plays an integral role in the child's perception of self-blame. This assumption seems logical when one examines research exploring the role of social support in the lives of survivors of childhood sexual abuse. Specifically, research in this area has focused on the roles of the mother-child relationship and father-child relationship within incest families.

Some research has shown that maternal support after disclosure moderates the severity of the symptomatology and psychopathology experienced by the child. For example, children who received higher levels of maternal support following disclosure seemed to manifest less psychopathology in response to the abuse (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Morrow & Sorell, 1989; Kendall-Tackett et al., 1993). Researchers have not yet addressed the issue of the relationship between the quality of the mother-child relationship and the specific aspects of child's self-blaming attributions, as was suggested in Hindman's (1989) model.

The limited research pertaining to the quality of

father-child relationships in families in which incest has occurred, with the father as the perpetrator, suggests that the quality of the paternal relationship is related to the child victim's self-reported levels of depression and anxiety (Lipovsky, Saunders, & Hanson, 1992). Results of this study also indicated that child victims reported greater relationship problems with their father/perpetrators than with their mothers. In general, the children in this study reported their relationships with their mothers to be unproblematic. Hence, the father-child relationship appeared to be a significant determining factor of the child victim's reported levels of distress. Furthermore, the quality of the father-child relationship appeared to override the impact of the supportive quality of the mother-child relationship (Lipovsky et al., 1992).

Purpose of the Study

As one might assume, the interactions among the relationships in Hindman's model are quite complex. The purpose of this exploratory study is gain some preliminary insight into the dynamic relationships amongst child survivors' perceptions of the quality of their social support network, their current attributional styles, and their perceptions of self-blame related to the sexual abuse. Of specific interest is the examination of the first two components of Hindman's model; that is, children's

perceptions about the quality of relationships they have with both their significant others and with the offender, and how these perceptions relate to the assignment of self-blame.

For the purpose of this study, the sample will include 8-17 year old female survivors of intrafamilial sexual abuse by a male perpetrator. The sample will be limited to female survivors who have been perpetrated against by a male offender as, according to both clinical and epidemiological research, the preponderance of child sexual abuse appears to be intrafamilial, with fathers or father-figures predominating as perpetrators against female children (Geffner, 1992). The target age range of 8-17 years has been used in similar research in the past and presents as a somewhat developmentally coherent group. As well, since previous research has suggested that there may be differential age effects in the attributional process (Hunter et. al., 1992), it would seem prudent to control for age to some extent.

The participants' general social support network is defined as mothers, fathers, teachers, and friends. With specific reference to Hindman's (1989) model, the category of 'significant other' will be operationalized as the child's maternal caregiver. It is recognized that the category of significant other may consist of many people whom the child views as significant, therefore, it would be

desirable to have the children identify these people themselves. However, for the sake of simplification and creating uniformity across subjects, the child's mother/maternal caregiver is chosen to represent the category of significant other as mothers/maternal caregivers are consistently found to be an important person in the lives of children.

Although the operational definitions of child sexual abuse vary across studies, the literature suggests that a contact definition is most commonly used. Hence, in this study, child sexual abuse is operationalized as the presence of physical contact of a sexual nature between the survivor and perpetrator. This includes fondling of the genitalia, buttocks or breasts, oral and anal sodomy performed on, or requested by the offender from the child, and attempted, actual, or simulated intercourse (Hunter et al., 1992).

Hypotheses

Hypothesis I. For the first and primary hypothesis it is expected that there will be a relationship between the quality of social support perceived as coming from each of the parents and the degree to which the participants blame themselves for the abuse. Specifically, it is expected that the perception of positive support coming from the offender will be associated with high levels of self-blame. Furthermore, it is expected that there will be a negative

association between self-blame and perceived maternal social support.

Hypothesis II. It is expected that participants who perceive a poor quality of social support from their maternal caregivers, friends, and teachers will have a negative attributional style.

Hypothesis III. It is also expected that participants with high self-blame will have negative attributional styles.

CHAPTER II

METHOD

Participants

Participants for the study consisted of a total of 10 8-17 year old girls who experienced intrafamilial sexual abuse by a father or father-figure. Local Children's Aid Society confirmation of the occurrence of the abuse was used as the criterion to determine the abuse status of the participants. At the time of data collection, all participants were engaged in some form of abuse-related treatment provided by an agency or private psychologist in the Windsor and Essex County areas.

Although it would have been ideal to collect data from participants prior to their receiving any treatment, hence somewhat controlling the effects of treatment, it was important that the participants currently be involved in a therapeutic relationship to facilitate their dealing further with any issues that may have arisen due to participation in this study. As well, there were concerns that the information requested of the participants may have been more readily accessible after treatment had begun.

Referral sources and recruitment procedures. Participants were recruited from referrals by several agencies in the Windsor area, including Essex County Children's Aids Society, Roman Catholic Children's Aid Society, Regional Children's Centre, Glengarda Child and

Family Services, and the Sexual Assault Crisis Centre of Windsor. As well, participants were recruited from referrals by a private psychologist in the Windsor area. Referrals were based on four primary inclusion criteria: (1) clients who are female; (2) clients between the ages of 8 and 17 years of age; (3) clients who had been perpetrated against by a father or father-figure (including biological fathers, step-fathers, common-law fathers); and (4) clients who had been engaged in treatment for at least 3 months. Moreover, suitability of a client for participation in the study was based on the clinical judgement of the clients' primary service providers.

There were an additional 11 children who met all inclusion criteria for the study, but did not participate in this study for various reasons. Eight did not participate based on the clinical judgement of their primary service providers. One potential participant was not included in the study due to parental unwillingness. Another decided to withdraw herself from the study. Finally, one potential participant was not included because her primary service providers did not feel that they had enough knowledge about the client to accurately assess self-blame or give background information. Thus, from the 21 potential participants, 10 (48%) participated in this study.

Measures

Measures were selected according to several criteria. First, the measures were chosen for the appropriateness of their use with the proposed target age range. Second, each measure that was selected presented response options in terms of concrete referents. That is, the child was presented with choices such as "not true for me", "sort of true for me", "very true for me", rather than requesting the child to rate the degree of a particular attribute along a numbered continuum as has been done in other research studies. Third, a measure of self-blame was selected that contained several items pertaining to more specific aspects of the abuse, rather than one global question, which had typically been used in previous research. See Table 1 for a list of the variables and the ranges of scores used in this study.

Children's Impact of Traumatic Events Scale-Revised (CITES-R). The CITES-R (Wolfe & Gentile, 1991) is a recently developed multi-dimensional instrument specific to the trauma associated with child sexual abuse. The CITES-R includes 78 items to which the child responds in a three choice format of "very true", "somewhat true", or "not true".

The CITES-R items, appropriate for children ages 8-16, were designed to yield 11 subscales which were derived by factor analysis of a shorter, 54-item version of the CITES

Table 1

Measures, Variables, and Ranges of Scores

Measure	Variables	Range of Scores
SSSC[a]		
Mother	Independent	1 to 4
Father	Independent	1 to 4
Teacher	Independent	1 to 4
Classmates	Independent	1 to 4
Close Friends	Independent	1 to 4
SPI[b]		
Mother	Independent	-20 to 20
Father	Independent	-20 to 20
CITES-R[c]		
Self-blame	Dependent	12 to 36
Social Support	Dependent	6 to 18

(table continues)

Table 1 (continued)

Measure	Variables	Range of Scores
KASTAN[d]		
Overall Attributional Style	Dependent	-24 to 24
Attributions for Pos. Events	Dependent	0 to 24
Attributions for Neg. Events	Dependent	0 to 24

Note.

[a]Social Support Scale for Children and Adolescents (Harter, 1985) measures active social support.

[b]Self-Perception Inventory (Soares & Soares, 1980) measures passive social support.

[c]Children's Impact of Traumatic Events Scale - Revised (Wolfe & Gentile, 1991)

[d]Children's Attributional Style Questionnaire (Seligman et al., 1984)

(Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991). The 11 subscales are grouped along four conceptual dimensions: Posttraumatic Stress Disorder (Intrusive Thoughts, Avoidance, Hyperarousal, and Sexual Anxiety scales); Social Support (Negative Reactions by Others, and Social Support scales); Abuse Attributions (Self-Blame/Guilt, Personal Vulnerability, Dangerous World, and Empowerment scales); and Eroticism.

Emphasis was placed on the Social Support subscale and the Self-Blame/Guilt subscale of the CITES-R in order to test the hypotheses of the study. Permission from the first author of the scale to utilize only these scales was obtained. As well, permission was obtained to modify the items such that they would be appropriately worded for the child's therapist or social worker to rate the participants rather than having the items directly administered to the children. For example, Item 16 from the original CITES-R Self-blame/Guilt scale which states "I was to blame for what happened.", was rewritten to read "This client feels that she was to blame for what happened". Item 27 from the original CITES-R scale which states "Most people who know about what happened are nice and understanding", was reworded to read "This client feels that most people who know about what happened are nice and understanding".

The Social Support subscale was used to assess the degree to which the participants feel that they are

receiving support around issues about the abuse and their disclosure. This subscale consists of 6 items that are randomly ordered throughout the CITES-R. Item scores range from one to three, with three indicating higher social support. The item scores are summed to obtain an overall subscale score.

Subscale reliability coefficients for the entire scale range from alpha values of .92 to .61, with the exception of one subscale whose reliability was shown to be an alpha value of .20; the Social Support subscale reliability alpha value was demonstrated to be .83 (Novak, 1993). Convergent validity of the Social Support subscale was evidenced by moderate correlations with Hudson's (1982) Child's Attitude Toward Mother, Child's Attitude Toward Father, and Index of Parent Attitude questionnaires (Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991).

The Self-Blame/Guilt subscale of the CITES-R was used to assess the degree to which the participants blame themselves for the abuse. This subscale consists of 12 items that are randomly ordered throughout the entire scale. Items are scored in the same manner as was described for the CITES-R Social Support subscale and yields an overall subscale score such that higher scores indicate a higher degree of self-blame. The reliability coefficient for this subscale is .88 (Novak, 1993) and has shown concurrent validity with high correlations with both overall positive

and negative KASTAN scores (Wolfe et al., 1991).

This subscale consists of more questions or statements regarding self-blame than has been traditionally used in research of this type. Typically asked questions, such as asking the child to rate how much they feel they are to blame for the abuse, are included in this scale and are useful for cross-validational purposes. The scale also taps into various aspects of self-blame that have been traditionally overlooked, such as behavioural and characterological self-blame. Items concerning behavioural self-blame focus on the child's feeling that their behaviour in some way caused the abuse to happen; for example, "This client feels that this happened to her because she acted in a way that caused it to happen". The content of the characterological self-blame items focus on issues related to personality traits or flaws that the child feels they have and that may have contributed to the cause of the abuse, such as "This client feels that this happened to her because she was not smart enough to stop it from happening".

Association between social support measures. Both the Social Support Scale for Children and Adolescents (SSSC) and the Self Perception Inventory (SPI) were employed in this study in order to gain information regarding the participants' perceptions of the social support they receive from their mothers/maternal caregivers and their

fathers/perpetrators. Theoretically, the two differ in terms of the underlying constructs that they measure. The SSSC, in essence, appears to measure the extent to which the respondent feels she actively 'gets' social support from various sources by what others actually do or say. The SPI, on the other hand, seems to measure the respondent's perception of what her mother (or father) thinks of her, reflecting a more latent type of support. Thus, the two measures tap different aspects of perceived social support, one more active and overt and the other more latent and covert.

Social Support Scale for Children and Adolescents (SSSC). This measure was developed by Harter (1985) and was used to assess participants' perceptions of the social support they receive from various sources. Specifically, the scale assesses the degree to which children perceive that significant others, such as parents, teachers, classmates, and close friends, regard them positively. The SSSC contains four subscales, each with six items. The first subscale, Parent Support, assesses the extent to which children feel their parents understand them and want to hear about their problems. The second, Classmate Support, assesses whether they perceive their classmates as friendly and/or as making fun of them. The third, Teacher Support, assesses the extent to which they feel that teachers help them to do their best and treat them fairly. The fourth

subscale, Close Friend, asks children if they have a close friend with whom they can talk about problems and complain to about things that bother them. The SSSC was designed for children in grades three through eight and has been used in research projects including participants up to 16 years of age (Harter, 1992; JoAnn Birt, personal communication, December 1993).

The scale consists of 24 items (6 items per subscale), presented in a consecutive order of one item per scale. A structured alternate format, which presents two contrasting descriptions, is used to reduce the tendency for children to give socially desirable responses and to legitimize either response choice. For example, Item 4 is as follows: "Some kids have a close friend who they can tell problems to BUT Other kids don't have a close friend who they can tell problems to." First, the child chooses which of the two descriptions is the most true for them, then the child rates the chosen description as 'really true' or 'sort of' true for them. The wording of the items is counterbalanced such that, for half of the items from each subscale, the first part of the statement reflects positive regard and the remaining items are worded such that lack of regard is presented in the first. Item scores range from one to four and are averaged for each domain, with low scores indicating perceived lack of regard.

Internal consistency of the subscales ranges from alpha

values of .72 (Close Friend) to .88 (Parent) for samples of elementary (grades 3-6) and junior high (grades 6-8) children (Harter, 1985). Intercorrelations amongst the subscales ranged from r=.27 (Teacher/Close Friend) to r=.57 (Classmate/Close Friend) with the majority in the low moderate range (r=.30 to r=.43). For the younger population, factor analysis revealed a three-factor structure corresponding to Parent, Teacher, and Classmate/Close Friend domains. For the older population of children, factor analysis revealed a four factor structure corresponding to the four domains of the scale. Convergent validity was demonstrated between reports of social support from each of the four domains and global self-worth as measured by the Self Perception Profile for Children (Harter, 1985). Moreover, convergent validity was demonstrated between reports of Classmate Support and Social Acceptance, as measured by the Self Perception Profile for Children (SPPC) (r=.62, grades 3-6) (Harter, 1985).

It is suggested in the Manual for the Social Support Scale for Children and Adolescents (Harter, 1985) that individual investigators who wish to explore social support from other sources may do so by expanding the existing subscales where appropriate. Therefore, for the purposes of gleaning information regarding the perceived social support coming from the maternal caregiver and the paternal offender separately, the Parent Support subscale was modified. Each

participant was administered these items in regard to each adult separately rather than in regard to her parents together, as the scale was originally worded. For example, Item 13 which states "Some kids have parents who treat their children like a person who really matters BUT Other kids have parents who don't usually treat their children like a person who really matters" was modified to read "Some kids have mothers who treat their children like a person who really matters BUT Other kids have mothers who don't usually treat their children like a person who really matters", and "Some kids have fathers who treat their children like a person who really matters BUT Other kids have fathers who don't usually treat their children like a person who really matters."

Self Perception Inventory (SPI). The SPI (Soares & Soares, 1975) is a set of 8 measures designed to assess children's self-concept as well as children's perceptions of how significant others perceive them. The 8 measures include Self-Concept, Reflected Self-Classmates (i.e., how the child thinks classmates perceive her/him), Reflected Self-Teacher, Reflected Self-Parents, Ideal Concept, Student Self, Perceptions of Others-Self Concept (ratings by others), and Perceptions of Others-Student (ratings by others).

For purposes of this study, only the Reflected Self-Parents measure was administered. Permission from the

authors was granted to administer the measure separately in reference to each of the parents rather than administering the items with reference to both parents together.

Each measure is structured in a similar manner and consists of 20 items formatted according to a semantic differential, using brief sentences to which the child responds along a four point continuum indicating which statement is most true for them. For example Item 19 is as follows: "My mom (or dad) thinks I'm a happy person/ My mom (or dad) thinks that I'm not a happy person". Item scores range from negative two to positive two, with higher scores indicating positive perceptions. Overall scores for each measure are obtained by summing item scores.

The SPI is appropriate for use with children in grades 1 through 12. Internal consistency reliability coefficients of all SPI scales range from alpha values of .89 to .66, with the Reflected Self-Parent scale having an internal reliability coefficient alpha value of .88 (Soares & Soares, 1980). Reported test-retest reliability coefficients, based on intervals of 3 to 4 weeks, are quite high ($\underline{r}$ = .69 to .89, with a median of .79) (Riggs, 1985). Furthermore, the test-retest reliability of the Reflected Self-Parent scale, based on 7 to 8 week intervals was reported to be .87 (Soares & Soares, 1980). Convergent validity has been evidenced by low to moderate correlations between the SPI scales and Coopersmith's Self-Esteem Inventory ($\underline{r}$ = .29 to

.68) (Riggs, 1985). Specifically, the Reflected Self-Parent scale was found to have a correlation of .63 with Coopersmith's Self-Esteem Inventory.

Children's Attributional Style Questionnaire (KASTAN). The KASTAN (Seligman, Peterson, Kaslow, Tannenbaum, Alloy, & Abramson, 1984) assesses typical ways in which children attribute causality for good and bad events. It is deemed suitable for use with populations in the 8-16 age range. Each of 48 items depicts a hypothetical good or bad event involving the child and two possible causes of the event. The respondent selects the cause from the pair that better describes why the event occurred. There are 16 separate questions for each of the following response choices: internal or external, stable or unstable, and global or specific. The two possible causes hold constant two of the attributional dimensions while varying the third. For example, an item that measures internality is as follows: "A good friend tells you that he hates you; (a) My friend was in a bad mood that day (external); (b) I wasn't nice to my friend that day (internal)". Thus, half of the questions provide good events to be explained, and half provide bad events.

The KASTAN is scored by assigning a 1 to each internal, stable, or global response, and a 0 to each external, unstable, or specific response. The overall attributional style of the child is reflected in the difference between

fortunate and unfortunate events that are assigned internal, stable, and global attributions. Self-enhancing attributional style for positive events is reflected in the sum of scores for positive events and self-deprecatory attributional style for negative events is reflected in the sum of scores for negative events.

Previous research with the KASTAN has shown a relationship between attributional style and depressive symptoms among elementary school children (Seligman, Peterson, Kaslow, Tannenbaum, Alloy, & Abramson, 1984) and depressed children (Kaslow, Rehm, & Siegel, 1984). Seligman et al. (1984) found responses to be relatively stable across time (r = .66).

History of Victimization Form (HVF). The HVF (Wolfe, Gentile, & Bourdeau, 1986) was used to collect information about the severity of the sexual abuse. This instrument, which is completed by the child's therapist/social worker, includes a checklist of sexually abusive experiences for which the informant estimates the frequency and duration of each behaviour, and reports the number of perpetrators, the relationship of the child to the perpetrator(s), and the type(s) of force or coercion used.

Factor analysis by Wolfe et al. (1986) revealed two orthogonal factors related to the severity of the abuse: 'seriousness of sexual abuse' (which included the variables 'sexual behaviours', 'force and coercion used', and 'number

of perpetrators') and 'course of the abuse' (which included the variables 'duration of the abuse', 'frequency of the abuse', and 'relationship to the perpetrator'). These factors accounted for 61% of the total variance in the overall severity of the sexual abuse (Gentile et al., 1988).

Procedure

After obtaining clearance from the Departmental Ethics Committee of the Department of Psychology at the University of Windsor, each participating agency was contacted. The nature of the study was explained and permission to solicit participation from the clients at the agency was requested. Subsequent to gaining approval at the agency level, individual therapists and social workers were then contacted. The researcher attended team meetings at the various agencies to explain the study and request that the individual therapists and social workers review their client files for clients who might be appropriate for participation in this study. Memos and phone contacts were utilized to follow up these requests.

After suitability for participation had been determined, the primary service provider consulted with the client's parent or legal guardian to explain the nature of the study (see Appendix A for initial information given to parents/guardians) and to request participation of their daughter. Subsequent to attaining initial parental/guardian

permission, arrangements were made to obtain signed informed consent from parents/guardians (see Appendix B). A convenient time and appropriate location for the testing session was then established between the researcher, primary service provider, and parent/guardian.

At the start of the session with each participant, the general purpose of the study was reviewed and issues around anonymity and confidentiality were discussed. The Informed Assent Form was discussed with, and signed by each participant (see Appendix C). It was then explained to each participant that she has the option to "pass" on any of the questions or discontinue testing all together.

Each session was approximately 30 to 60 minutes in duration. The four scales administered by the researcher (KASTAN, SPI-Mother, SPI-Father, and SSSC) were presented to the participants in counterbalanced order. At the end of the session, the child was asked if she had any questions pertaining to the study and was probed for the presence of any distress (see Appendix D for Debriefing of Participants). The participant was then thanked for her participation and cooperation.

Since all children were in treatment regarding abuse issues at the time of their participation, it was decided that it was more appropriate for the therapist/social worker to give their clinical opinion, based on their knowledge of the child, about any information directly associated with

the sexual abuse. Hence, the CITES-R was modified and the therapist/social worker completed this questionnaire. The therapist or social worker also completed the HVF based on their background knowledge of the case.

CHAPTER III

RESULTS

Demographic Characteristics and Background Information

The total sample consisted of 10 females who ranged in age from 8 to 17 years old, with a mean age of 12.6 years (*SD* = 10.8 months). Tables 2 and 3 present the demographic variables describing the sample. The number of months since disclosure of abuse ranged from 4 to 48, with a mean of 26.4 months (*SD* = 15.3). The number of months the participants had been in treatment ranged from 4 to 48, with a mean of 19 months (*SD* = 15.68). Since one of the participants had been in treatment before the occurrence or disclosure of sexual abuse, the number of months in treatment for this participant was deemed to equal to the number of months since disclosure. It was assumed that treatment after the disclosure, but not before, included an abuse-related component. Table 3 presents the living arrangements of the participants at the time of participation, with over half (*n* = 6) living with one or both biological parents. Further, half of the participants (*n* = 5) had a maternal caregiver who was their biological mother, while 3 had a foster mother, one an adoptive mother, and 1 a stepmother.

Information regarding the severity of abuse experienced by the participants was collected using the HVF. The frequency of abuse experienced by the participants ranged from 0.5 to 4 times a week, with a mean of 2.5 (*SD* = 1.26).

Table 2

Demographic Characteristics of the Sample (N=10)

	Mean	SD	Median	Mode
Age (in years)	12.60	2.86	12.79	----[a]
Months since disclosure of abuse	26.40	15.31	24.00	24.00
Months receiving treatment	19.00	15.68	15.5	24.00

Note.

[a]No mode is reported for Age as all participants were different ages.

Table 3

Living Arrangements of the Sample (N=10)

Living Arrangement	n	%
Biological mother	4	40
Foster placement	3	30
Both biological parents	1	10
Both adoptive parents	1	10
Biological father	1	10

Duration of the abuse experienced by the participants ranged from 0.25 to 84 months, with a mean of 35.47 months (SD = 33.82). Of the 10 participants, 5 were perpetrated against by their biological fathers, 4 by their step-fathers, and 1 by her adoptive father. Table 4 presents a breakdown of the use of force or coercion to engage in the abusive acts, with half (n = 5) of the participants experiencing the use of implicit threats of removal of affection or privileges and 4 of the participants being threatened with physical punishment. The different forms of abuse that were experienced by the participants ranged from exposure of the child to adult genitalia to anal intercourse. Frequently reported forms of abuse included acts that included: being exposed to adult genitalia, being touched over their clothes in a sexual manner, being fondled by the perpetrator or being instructed to masturbate the perpetrator, and vaginal intercourse.

Overview of Data Analysis

Since the sample in this study is highly selective and quite small, the form of the underlying population distribution of the variables measured cannot be assumed to conform to the normal curve (Gibbons, 1976). Hence, nonparametric statistical methods were employed as they are not based on the assumption of the normality of the underlying distribution, as are parametric statistics. In

Table 4

Severity of Abuse: Use of Coercion or Force (N=10)

Coercion or Force	n(*)	%
Threat of removal of affection, privileges, or other positives	5	50
Threat of physical punishment	4	40
Status differential	3	30
Offers of rewards, affection, privileges	3	30
Use of physical punishment	2	20
Threat of death	2	20
Other or unknown	2	20
Use of blackmail to gain compliance	1	10

Note.

(*) These are not mutually exclusive.

this situation nonparametric statistical methods are considered as valid as their parametric counterparts (Gibbons, 1971; Siegel & Castellan, 1988).

Spearman rank-order correlation coefficients were determined in order to glean preliminary information regarding the relationship between the variables under study. As noted in Table 5, correlations between the independent and dependent variables were in the expected directions.

Next, scores from each social support measure were dichotomized according to the median value for that variable. These dichotomized social support groups were then employed as independent variables in a series of Mann-Whitney tests to compare groups of participants on the dependent variables under study, namely self-blame and attributional style. It is important to note that the dichotomized groups reflect relatively high and low values of each variable, rather than absolute high and low scores obtained from established cutoff scores.

Since the hypotheses under study are directional in nature, as the theory upon which they are based would warrant, one-tailed tests of significance were used in all analyses. Moreover, all Mann-Whitney tests of significance were corrected for ties. Table 6 presents descriptive statistics for the sample on all scales and measures used in the present study.

Table 5

Spearman Rank-order Correlations

Scale	2	3	4	5	6	7
1. SSSC-Mother	-.75**	.39	.20	.09	.71*	-.62*
2. SSSC-Father		-.25	-.60*	-.13	-.49	.63*
3. SSSC-Teacher			.07	.17	-.08	-.36
4. SSSC-Close Friend				.24	-.20	-.32
5. SSSC-Classmates					.12	-.03
6. SPI-Mother						-.10
7. SPI-Father						

(table continues)

Note.

* $p < .05$

** $p < .01$

Table 5 (continued)

Scale	8	9	10	11	12
1. SSSC-Mother	-.41	.59*	.25	.54	.02
2. SSSC-Father	-.10	-.25	-.11	-.20	-.13
3. SSSC-Teacher	-.50	.32	-.13	-.05	-.43
4. SSSC-Close Friend	.44	.31	-.34	-.39	.27
5. SSSC-Classmates	.29	.31	-.07	.22	.25
6. SPI-Mother	-.10	.59*	.32	.62*	-.15
7. SPI-Father	.41	-.21	-.17	-.35	-.17
8. Self-blame		-.54	-.39	-.46	.19
9. Abuse-related Support			.72**	.81**	-.46
10. KASTAN-Overall				.81**	-.87**
11. KASTAN-Positive					-.55*
12. KASTAN-Negative					

Note. * $p < .05$, ** $p < .01$

Table 6

Descriptive Statistics for the Measures Used (N=10)

Measure/Scale	Mean	SD	Median	Mode
SSSC - Mother	3.03	1.13	3.67	4.00
SSSC - Father	2.35	1.03	2.17	1.50
SSSC - Classmates	3.08	0.70	3.25	3.67
SSSC - Teacher	3.17	0.87	3.25	3-4
SSSC - Close Friend	3.77	0.31	3.83	4.00
SPI - Mother	12.80	18.43	18.00	----[a]
SPI - Father	-5.30	20.71	1.00	----[a]
KASTAN - Overall	1.40	4.58	3.00	5.00
KASTAN - Positive	11.80	3.26	12.00	----[b]
KASTAN - Negative	10.40	2.12	11.00	11.00
CITES-R - Self-blame	20.70	4.03	21.00	19-20
CITES-R - Social Support	13.80	2.15	14.00	12-14

Note.

[a]No mode for these variables.

[b]No mode for these variables is reported as the distribution is trimodal.

Social support measures. Two different measures were used to tap the construct of perceived social support coming from the participants' maternal caregivers and from the offenders. A significant association was obtained between the scores of the mother and father subscales of the SSSC, (r_s = -.75, p < .01). Hence, as levels of perceived active social support from mother increase, levels of perceived active social support from the perpetrator decrease.

Within the SPI, which taps perceptions of latent support, no significant association was revealed between mother and father scores. That is, levels of perceived latent social support from mother were not associated with levels of perceived latent social support from the perpetrator. However, significant associations were found between the two measures of social support coming from mother (r_s = .71, p < .05), and from father (r_s =.63, p < .05) such that levels of perceived active and latent social support were found to be positively related. Furthermore, perceptions of active social support from mother were negatively associated with perceptions of latent social support from father (r_s = -.62, p < .05), yet the opposite was not found between perceptions of active support from father and latent support from mother.

Hypothesis I. To test the first hypothesis regarding levels of parental social support and self-blame, a series of Mann-Whitney tests were employed. Scores on each social

support measure were dichotomized into high and low groups and mean differences on self-blame were tested. See Table 7 for the means of the dichotomized parental social support groups on self-blame.

Group differences between high and low SSSC-Mother groups on the self-blame variable approached significance (U = 5, p = .058). That is, those participants who perceived low active maternal social support had higher levels of self-blame than those who perceived hign active maternal social support.

Although the mean differences on self-blame between those in the high SPI-Mother group and those in the low SPI-Mother group did not reach statistical significance, the direction of the difference was in the hypothesized direction (U = 8, p = .17). That is, there was a trend for participants who perceived high latent maternal support to blame themselves less than those who perceived low latent maternal social support.

Significant group differences were not found for self-blame scores between participants in the high active paternal social support and those in the low active paternal social support. Although no significant group differences on self-blame were found when the groups were dichotomized on SPI-Father, the direction of the difference was in the expected direction (U = 6.5, p = .10). Hence, for this social support variable there was a trend for participants

Table 7

Means of High and Low Social Support Groups on Self-blame

Social Support		Self-blame(*)	U	p
SSSC-Mother				
	High	4.0	5.0	.058
	Low	7.0		
SPI-Mother				
	High	4.6	8.0	.17
	Low	6.4		
SSSC-Father				
	High	5.9	10.5	n.s.
	Low	5.1		
SPI-Father				
	High	6.7	6.5	.10
	Low	4.3		

Note.

n.s. Not significant

(*) Higher scores indicate higher levels of self-blame.

who perceived high latent, but not active, paternal social support to blame themselves more than those who perceived low latent paternal social support.

Hypothesis II. To test the second hypothesis, regarding levels of social support and attributional style, a series of Mann-Whitney tests were similarly performed. It should be noted that all the participants had KASTAN scores below 7 which classified them all as having overall negative attributional styles. Hence, in the following analyses, using attributional style as the dependent variable, group differences reflected degrees of negative attributional style where higher scores reflected less negative attributional styles. Scores on each of the seven social support measures were dichotomized into high and low groups and mean differences on KASTAN scores were tested. Moreover, groups were also examined for differences on KASTAN scores of Attributions for Positive Events and Attributions for Negative Events. Tables 8, 9, and 10, respectively, report the means of the dichotomized social support groups on KASTAN, Attributions for Positive Events, and Attributions for Negative Events scores, respectively.

Social support from mothers. Although no significant group differences emerged for attributional style between the high and low SSSC-Mother groups, the direction of the difference between the means was in the hypothesized direction (U = 8, p = .17). That is, those participants who

Table 8

Means of High and Low Social Support Groups on KASTAN Scores

Social Support	KASTAN(*)	U	p
SSSC-Mother			
High	6.4	8.0	.17
Low	4.6		
SPI-Mother			
High	6.9	5.5	.068
Low	4.1		
SSSC-Father			
High	5.4	12.0	n.s.
Low	5.6		
SPI-Father			
High	4.1	5.5	.068
Low	6.9		

Note. (table continues)

n.s Not significant

* $p < .05$

(*) Higher scores indicate less negative attributional style.

Table 8 (continued)

Social Support	KASTAN	U	p
SSSC-Teacher			
High	5.6	12.0	n.s.
Low	5.4		
SSSC-Close Friend			
High	5.3	11.0	n.s.
Low	5.8		
SSSC-Classmates			
High	5.8	11.0	n.s.
Low	5.2		

Note.

n.s. Not significant

Table 9

Means of High and Low Social Support Groups on Attributions of Positive Events Scores

Social Support	Attributions for Positive Events(*)	U	p
SSSC-Mother			
High	7.3	3.5	.03*
Low	3.7		
SPI-Mother			
High	7.6	2.0	.01*
Low	3.4		
SSSC-Father			
High	4.6	8.0	.17
Low	6.4		
SPI-Father			
High	4.0	5.0	.056
Low	7.0		

(table continues)

Note.

n.s. Not significant

* $p < .05$

(*) Higher scores indicate that more self-enhancing attributions were made for outcomes of positive events.

Table 9 (continued)

Social Support	Attributions for Positive Events	U	p
SSSC-Teacher			
High	6.1	9.5	n.s.
Low	4.9		
SSSC-Close Friend			
High	4.8	6.5	n.s.
Low	6.6		
SSSC-Classmates			
High	6.7	7.5	n.s.
Low	4.3		

Note.

n.s. Not significant

Table 10

Means of High and Low Social Support Groups on Attributions for Negative Events Scores

Social Support	Attributions for Negative Events(*)	U	p
SSSC-Mother			
High	5.1	10.5	n.s.
Low	5.9		
SPI-Mother			
High	4.4	7.0	.12
Low	6.6		
SSSC-Father			
High	4.6	8.0	n.s.
Low	6.4		
SPI-Father			
High	6.2	9.0	n.s.
Low	4.8		

Note.

n.s. Not significant

(*) Higher scores indicate that more self-deprecatory attributions were made for the outcomes of negative events.

Table 10 (continued)

Social Support	Attributions for Negative Events	U	p
SSSC-Teacher			
High	4.9	9.5	n.s.
Low	6.1		
SSSC-Close Friend			
High	5.5	11.5	n.s.
Low	5.5		
SSSC-Classmates			
High	5.7	12.0	n.s.
Low	5.3		

Note.

n.s. Not significant

perceived high active maternal support tended to have less negative attributional styles than those who perceived low active maternal support. Significant group differences were found for Attributions for Positive Events scores between high and low active maternal support groups (U = 3.5, p < .05). Hence, participants who perceived high active maternal support made significantly more self-enhancing attributions for positive events than did participants who perceive low active maternal support. No group differences emerged between levels of active maternal social support when Attributions for Negative Events scores were tested.

Group differences for KASTAN scores between the high SPI-Mother group and the low SPI-Mother group approached significance (U = 5.5, p =.068). Hence, those participants who perceived high latent maternal support seemed to have less negative attributional styles than those who perceived low latent maternal support. Statistically significant differences were obtained between high and low SPI-Mother groups for Attributions for Positive Events scores (U =2, p < .05). That is, those participants who perceived more latent maternal support had higher Attributions for Positive Events scores. Although no group differences on Attributions for Negative Events emerged between levels of latent maternal social support, the direction of the difference was in the expected direction (U = 7, p = .12) such that those in the high group tended to make somewhat

less self-deprecatory attributions than participants in the low group.

Social support from perpetrators. Significant group differences did not emerge for overall KASTAN scores between high and low SSSC-Father groups. Moreover, although no significant group differences on Attributions for Positive Events scores or Attributions for Negative Events scores were found between high and low SSSC-Father groups, the direction of the difference for Attributions for Positive Events was also in the hypothesized direction (U = 8, p = .17), whereas Attributions for Negative Events were not. Hence, there was a tendency for participants who perceived high active paternal support to make somewhat fewer self-enhancing attributions for the outcomes of positive events.

Group differences for KASTAN scores between the high SPI-Father group and the low SPI-Father group approached significance (U = 5.5, p =.068). Hence, those participants who perceived more latent paternal social support were found to have somewhat more negative attributional styles than those who perceived less latent support from their fathers. Further, group differences between high and low SPI-Father groups for Attributions for Positive Events scores approached significance (U = 5, p = .056) and no difference was obtained for Attributions of Negative Events scores. That is, participants who perceived high latent support from their fathers had a tendency to make more global, internal,

and stable attributions for the outcomes of negative events than did participants who perceived low latent paternal support.

Social support from teachers, classmates, and close friends. No statistical group differences were found for KASTAN scores when the participants were grouped into high and low perceived social support coming from teachers, classmates, or close friends. Moreover, no statistically significant group differences between the high and low SSSC-Teacher, SSSC-Classmates, nor SSSC-Close Friends were found for Attributions for Positive or Negative Events scores.

Hypothesis III. To test the third hypothesis regarding levels of self-blame and attributional style, a series of Mann-Whitney tests were performed. The dichotomized self-blame groups were used and mean differences on the KASTAN were tested. Moreover, the high and low self-blame groups were compared on both Attributions for Positive Events scores and Attributions for Negative Events scores. See Table 11 for the means of the high and low self-blame groups on the KASTAN, Attributions for Positive Events and Attributions for Negative Events scores.

When self-blame scores were dichotomized into high and low groups, the difference between the groups on KASTAN scores approached significance ($U = 5.5$, $p = .068$) such that high self-blamers tended to have more negative attributional styles than did low self-blamers. Moreover, although

Table 11

Means of High and Low Self-blame Groups on Attributional Style Measures

	Self-blame			
	High	Low	U	p
KASTAN[a]	4.1	6.9	5.5	.068
Attributions for Positive Events[b]	4.3	6.7	6.5	.10
Attributions for Negative Events[c]	6.5	4.5	7.5	.14

Note.

[a]Higher scores indicate a less negative attributional style.

[b]Higher scores indicate that more self-enhancing attributions were made for the outcomes of positive events.

[c]Higher scores indicate that more self-deprecatory attributions were made for the outcomes of negative events.

differences between self-blame groups did not reach statistical significance on Attributions for Positive Events scores (U = 6.5, p = .10), nor on Attributions for Negative Events scores (U = 7.5, p = .14), both tests revealed that the differences between the means were in the hypothesized directions.

Abuse-related social support. In order to glean information regarding levels of social support specifically related to abuse, scores on the therapist-rated CITES-R Social Support subscale were dichotomized into high and low groups. Group differences on abuse-related social support were tested with the following as dependent variables: other social support measures, attributional style, and therapists' ratings of self-blame. See Table 12 for the means of the high and low abuse-related social support groups.

Group differences for both SSSC-Mother scores and SPI-Mother scores between the high and low CITES-R Social Support groups approached significance (U = 5.5, p = .076 and U = 5, p = .068, respectively). Hence, those participants whose therapists rated them as perceiving high social support specifically related to their abuse rated themselves as having somewhat more active and latent maternal social support than those who were rated as perceiving lower social support around their abuse. No group differences were found for the other social support

Table 12

Means of High and Low Abuse Related Social Support Groups on All Variables

	Abuse-related Social Support			
	High	Low	U	p
SSSC-Mother	6.58	3.88	5.5	.076
SPI-Mother	6.67	3.75	5.0	.068
SSSC-Father	4.50	7.00	6.0	.100
SPI-Father	5.17	6.00	10.0	n.s.
SSSC-Classmates	6.33	4.25	7.0	n.s.
SSSC-Teacher	5.83	5.00	10.0	n.s.
SSSC-Close Friends	5.67	5.25	11.0	n.s.
Self-blame	5.08	6.13	9.5	n.s.
KASTAN	7.17	3.00	2.0	.014*
Attributions for Positive Events	7.00	3.25	3.0	.025*
Attributions for Negative Events	4.25	7.83	4.5	.048*

Note.

n.s. Not significant

* $p < .05$

measures although all mean differences were in the expected directions.

Whereas no group differences between participants who perceived high and low specific social support were found for self-blame, group differences emerged for measures of attributional style. Specifically, significant group differences emerged for overall KASTAN scores ($U = 2$, $p < .05$), such that those participants whose therapists rated them as perceiving more specific social support regarding their abuse had significantly less negative attributional styles than those whose therapists rated them as perceiving low abuse-related social support. Moreover, these groups significantly differed on the amount of self-enhancing attributions for positive events ($U = 3$, $p < .05$) and self-deprecatory attributions for negative events ($U = 4.5$, $p < .05$). That is, those participants whose therapists rated them as perceiving higher levels of abuse-related social support made more self-enhancing attributions with regards to the outcome of positive events and less self-deprecatory attributions with regards to the outcome of negative events than did those whose therapists rated them as perceiving lower levels of abuse-related social support.

Demographic and abuse-related factors. Since the scope of the analyses of this study were limited by the small sample size, it was not possible to include demographic and abuse-related characteristics as covariates in the above

analyses. In order to shed some light on the effects of these variables, a series of Mann-Whitney tests were performed by dichotomizing each of the demographic and abuse-related variables and testing for group differences on each of the following variables: age, length of time in treatment, months since disclosure, duration of the abuse, and frequency of the abuse.

Age. Significant group differences on overall KASTAN scores were found between older and younger participants ($U = 3$, $p < .05$). Furthermore, significant age differences also emerged for Attributions for Positive Events ($U = 3.5$, $p < .05$) scores and group differences for Attributions for Negative Events scores approached significance ($U = 5.5$, $p = .065$). That is, older participants tended to have more negative overall attributional styles, had less self-enhancing attributions for positive events, and more self-deprecatory attributions for negative events than did younger participants. Moreover, significant age differences emerged for SPI-Mother scores ($U = 4$, $p < .05$), such that older participants tended to perceive less latent maternal social support than did younger participants.

Length of time in treatment. No differences emerged based on length of time in treatment. Hence, length of time in treatment did not seem to effect perceived level of maternal or paternal support, self-blame, nor attributional style.

Months since disclosure. Significant group differences on CITES-R Social Support scores were found between participants who had disclosed longer ago than those who had disclosed more recently ($U = 3$, $p < .05$). That is, participants who disclosed less than two years ago were rated by their therapists as perceiving more social support around their abuse than those who disclosed two or more years ago. Furthermore, significant group differences also emerged for SSSC-Teacher scores ($U = 2.5$, $p < .05$), such that participants who had disclosed more recently perceived more social support coming from their teachers than did those who disclosed longer ago.

Duration of abuse. Significant group differences with regards to SSSC-Classmates scores were found between those participants who experienced abuse over a longer period of time than those who experienced abuse over a shorter period of time ($U = 4$, $p < .05$). That is, those participants whose abuse experiences extended over a longer period of time perceived less social support from their classmates than did those whose abuse experiences were of a shorter duration.

Frequency of abuse. Significant group differences emerged for SPI-Mother scores between participants whose abuse experiences were high in frequency and those whose experiences were less frequent ($U = 4$, $p < .05$). Hence, those participants who experienced abuse more frequently perceived significantly less latent maternal social support

than participants whose abuse experiences occurred less frequently.

In summary, statistical analyses revealed that the self-blame and attributional style variables were related to active and latent maternal social support. Furthermore, the relationships between latent paternal support and self-blame and attributional style variables were in the hypothesized directions. Moreover, the relationship between self-blame and attributional style was in the expected direction. Finally, therapist-rated abuse-specific social support was related to the maternal social support variables and attributional style variables. Figure 2 presents a schematic representation of the significant and marginal relationships found among the variables used in the present study.

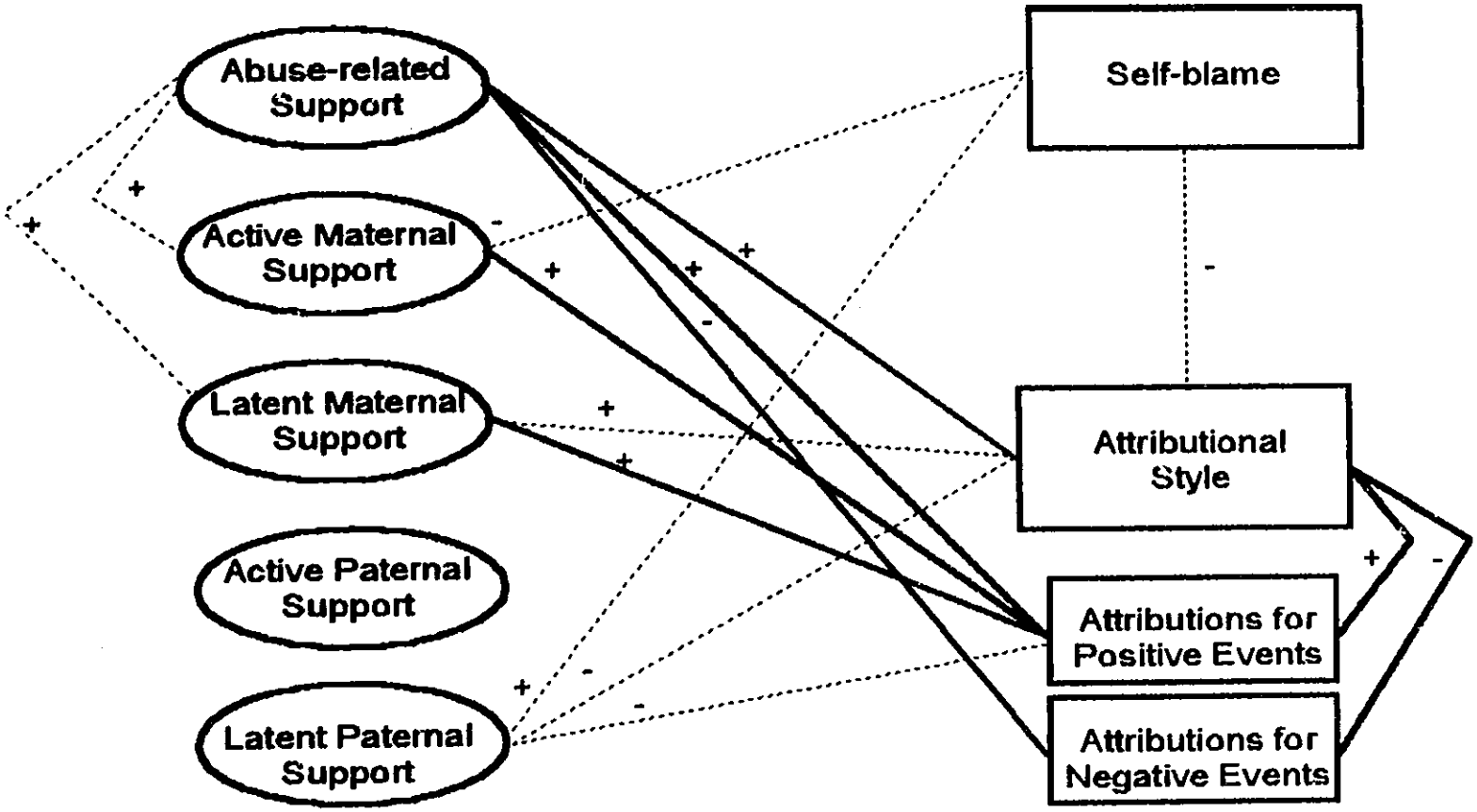

Figure 2. Schematic Representation of Relationships Among Variables

CHAPTER IV

DISCUSSION

The purpose of the present study was to explore the utility of Hindman's (1989) model and gain some insights into the dynamic relationships existing amongst child survivors' perceptions of the quality of their social support network, their current attributional styles, and their perceptions of self-blame for the abuse. Hindman's (1989) model implicates the child survivor's perceptions of social support from various sources as an integral component of the process of evaluating self-blame. Briefly, this model predicts that the worst scenario would be when child survivors evaluate their relationships with significant others as poor and with the offender as good. These children would be expected to have the highest levels of self-blame. Conversely, the lowest levels of self-blame would be expected when relationships with significant others are deemed to be good and with the offender poor, with varying degrees in between.

Hence, in the present study, ten child survivors of father-daughter incest were requested to rate their perceptions of the quality of social support from various sources, including their mothers, fathers, teachers, classmates, and close friends. Furthermore, each participant completed an attributional style questionnaire

to gain information regarding the ways in which they attribute the causes of outcomes for fortunate and unfortunate events. To obtain information regarding levels of self-blame and abuse-related social support, primary service providers were requested to rate their clients on these variables using a modified version of the CITES-R (Wolfe & Gentile, 1991).

Findings of the Present Study

Although the results of the present study must be interpreted with caution due to the small sample size and the nature of statistical tests employed, the findings lend preliminary support to Hindman's (1989) relationship model describing the manner in which child survivors come to attribute self-blame for their abuse experiences. Specifically, support was found for a positive relationship between social support coming from mothers and a lower level of self-blame experienced by the survivor. Similarly, social support from the offender was negatively related to levels of self-blame in the manner proposed by the model. These findings are partially supported by past research conducted by Harter and Nowakowski (1987). Specifically, these researchers found that social support from significant others, using the SSSC, was directly related to scores on the Dimensions of Depression Profile for Children and Adolescents, which contains a 6 item subscale tapping

general self-blaming attributions.

Social support and self-blame. The hypothesis that child survivors' perceptions of their social support network would be related to levels of self-blame was supported by the present study. Specifically, those participants who perceived higher levels of both active and latent maternal social support had lower levels of self-blame than did participants who reported lower levels of maternal social support. With regard to support from the offender, there was a trend for latent, but not active support to influence the degree to which survivors blamed themselves for the abuse. Specifically, participants who perceived higher levels of latent paternal support (scores on the SPI ranging from 2 to 22) tended to have higher levels of self-blame than those who perceived lower levels of support from their fathers (scores on the SPI ranging between 1 and -40).

A reason for the differential influence of active and latent support from fathers but not from mothers may be accounted for by the following rationale. Because the mother is present in the home, the child is potentially exposed to behaviours that would lead to the perception of both active and latent forms of support. However, for most of the participants in the sample (80%), the offender is no longer residing in the same home as the survivor. As a result, the child has only limited opportunity to be exposed to behaviours that could lend themselves to influencing

their perceptions of active social support.

Interestingly, Hindman's (1989) prediction regarding the relationship of perceived social support from significant others who are in closer relation to the offender seemed to be somewhat supported, although not directly tested. That is, while a relationship was found between maternal support and self-blame, no such relationship was found between self-blame and social support coming from sources more removed from the offender, such as teachers, classmates and close friends. This would seem to suggest that perceived support coming from those who are closer in relation to the offender may be more significant in the perception of self-blame.

Social support and attributional style. The hypothesis that levels of social support would be related to attributional styles was partially supported. Although all the participants in the study were found to have generally negative attributional styles, levels of perceived support were related to the degree of negativity of the participants' attributional style. Specifically, participants who perceived higher levels of both active and latent maternal support tended to have less negative attributional styles, than did those participants who perceived low levels of maternal support. Furthermore, these participants' attributional styles were characterized by more self-enhancing attributions for the outcomes of

positive events and less self-deprecatory attributions for the outcomes of negative events.

In terms of perceived support coming from the offender, participants who reported perceiving higher latent support tended to have more negative attributional styles than did those participants who perceived lower latent support. The relationship between active paternal support and attributional style was somewhat weaker, yet in the same direction. Moreover, attributional styles of participants who perceived higher latent support from the offender made somewhat fewer self-enhancing attributions concerning the outcomes of positive events and more self-deprecatory attributions about the outcomes of negative events.

These findings make sense considering the framework of past research concerning the attributional style of survivors. For instance, such research has documented the relationship between negative attributional styles and more severe abuse experiences (Hoagwood, 1990; Stern, 1989; Wyatt & Newcomb, 1990). The findings from the present study suggest the possibility that perceived parental social support may be acting as a mediating variable between the impact of the characteristics of the abuse experience and ensuing attributional styles of survivors. For example, use of coercion has been found to put survivors at greater risk for developing negative attributional styles (Wyatt & Newcomb, 1990). As discussed by Rutter (1989), social

support may act as a protective factor, buffering the effects of abuse on attributional style.

Levels of perceived social support from teachers, classmates, and close friends did not seem to be related to the attributional styles of the participants in this study. This buffering effect of social support between abuse characteristics and attributional style may not develop when the social support is perceived as coming from other sources for similar reasons as proposed in Hindman's model. That is, in relation to attributional style, perhaps social support does not play as important a role when it is perceived as coming from more distal sources.

Attributional style and self-blame. The hypothesis regarding the relationship between attributional style and self-blame was supported in the present study. Specifically, participants with higher levels of self-blame had more negative attributional styles than participants with lower levels of self-blame. Moreover, their attributional styles were characterized by fewer self-enhancing attributions for the outcomes of positive events and more self-deprecatory attributions for the outcomes of negative events. Although future research would need to further examine this relationship, one explanation could be that the assignment of self-blame for the abuse leads survivors to perceive less personal control over positive events and take more responsibility for negative events in

their lives.

Abuse-related social support. Results from this study suggested that only participants' perceptions of maternal support were related to levels of therapist-rated perceived social support specifically pertaining to the abuse. Specifically, participants who were reported by their therapists to perceive higher levels of support around abuse related issues also reported themselves as perceiving higher active and latent social support from their maternal caregivers. This positive relationship between participants' self-reports about perceived maternal support and therapists' ratings of perceptions of abuse-related support may be interpreted as an indicator of the validity of therapists' ratings. Abuse-specific support was not related to perceptions of social support coming from the other sources explored in this study.

Furthermore, participants with high levels of perceived abuse-related support had less negative attributional styles than those who perceived low levels of abuse-related support. Moreover, their attributional styles were characterized by more self-enhancing and less self-deprecatory attributions for the outcomes of positive and negative events. Again, a similar rationale may be used to interpret these relationships. Perhaps support around abuse-related issues facilitates survivors' feelings of general personal control over positive events in their lives

and less responsibility for negative events.

Demographic variables and characteristics of the abuse experience. Results from this study suggest that older participants (approximately 13 years and older) tended to have more negative attributional styles that are characterized by less self-enhancing and more self-deprecatory attributions than younger participants. These older participants also perceived less latent maternal support than younger participants. One hypothetical explanation of the fact that active maternal support did not seem to vary across older and younger participants is posited here. Perhaps this decrease in levels of perceived latent maternal support with the older participants may be linked to issues typical of mother-adolescent daughter relationships in general rather than issues related specifically to sexually abused adolescents. Another explanation for this age difference could be related to the course of cognitive development. That is, older participants have reached a level of cognitive development that enables them to think more critically about the more abstract issues (Hetherington & Parke, 1986) such as latent social support as measured by the SPI. In order to test these hypotheses, future research may want to compare levels of perceived active and latent maternal support of sexually abused adolescents and non-abused adolescents.

Length of time the participants have been receiving

treatment did not seem to affect the perceived levels of maternal or paternal social support, self-blame, nor attributional style of the participants in this sample. This may be due to the great variability of the length of time participants had been in treatment. Hence, the variability of within each of the high and low groups may have diluted any treatment effects.

Participants who disclosed about the abuse more recently perceived more social support around abuse-related issues and more social support from their teachers than did participants who disclosed longer ago. Since the time since disclosure in this sample ranges from 4 months to 4 years, the more open and less stigmatizing atmosphere around disclosures of abuse in recent years may account for these group differences. Another explanation may be that over time people in the survivors' lives expect an abatement of symptomotolgy and that survivors 'should' to return to 'normal' functioning. Hence, the lack of perceived support may be due to a perceived lack of tolerance for the ongoing long-term effects of sexual abuse by people in the survivors' social networks.

Participants whose abuse experiences extended over longer periods of time (e.g., three years and over) perceived less social support coming from their classmates than did those whose abuse experiences were of a shorter duration (e.g., one year and under). One explanation for

this may be that the longer the abuse goes on, the more different and isolated survivors may feel from their peers. This hypothesis would need to be specifically addressed in future research to draw any substantive conclusions.

Participants who experienced abuse more frequently (e.g., over twice a week) perceived less latent social support from their mothers than participants whose abuse experiences occurred less frequently (e.g. twice a week or less). One hypothetical explanation for this finding may be that perhaps with increased frequency of abuse, survivors begin to feel that, even though their mothers are showing active support, their mothers do not think highly of them in general. The specific dynamics of the relationship between these variables remains to be explored.

Limitations of the Present Study

The primary limitation of the present study is the small sample size of ten participants. Although all statistical procedures employed are valid and appropriate for use with samples of this size, the power of the analyses is greatly reduced. Hence, a larger sample may have produced larger and more conclusive results. Given the exploratory nature of this study, the number of statistical tests that were used to investigate this small data set is understandable, nonetheless it remains a limitation.

Reasons for the small sample are twofold. First, it

was decided that the importance of homogeneity of the sample would take precedence over including a more heterogenous sample of participants. One cost of a highly homogeneous sample population is the lack of generalizability of these findings to groups of survivors who differ in terms of their gender, age, and their relationship to the perpetrator. Second, the difficulty incurred in participant recruitment served to greatly reduce sample size. As was mentioned in the Method section, participation rate was 48% of known potential participants. Approximately 8 of the 10 potential participants, who met all inclusion criteria for the present study, were deemed inappropriate for participation due to situational and/or emotional factors.

Despite the attention paid to creating a homogeneous sample, there were a few variables which it would have been preferable to control more stringently (eg., age, time since disclosure, length of time in treatment, etc). Although every attempt was made to examine the effects of these variables, a larger sample would have permitted either more control at the sampling and/or statistical levels.

Another limitation of the present study is the issue of obtaining therapist ratings of self-blame and abuse-related social support rather than obtaining self-reports from participants. Although this was unavoidable, the congruence of client ratings and therapist ratings of their client's level of self-blame requires further empirical validation.

A less significant measurement issue is the use of measures with 17-year-old participants that were originally developed and employed with samples up to the age of 16. For example, although the Social Support Scale for Children and Adolescents was originally developed on children in grades 3 through 8, the author of the measure has employed the SSSC with populations as old as 16 years. The application of this measure, as well as the KASTAN, to 17-year-olds should not theoretically pose a problem as there is no reason to assume that a 16-year-old would respond to the items significantly differently than a 17-year-old.

Strengths of the Present Study

A number of aspects of the present study are particularly worthy of discussion. First, measures were chosen that focus on the quality and nature of perceived support from the participants' point of view, rather than obtaining an objective checklist of supportive behaviours performed by people in the participants' social network. This distinction is important when one considers the possibility that particular behaviours may be interpreted as supportive by one participant yet may be thought of unhelpful and unsupportive by another. Hence, attention was paid to perceptions of support regardless of any objective measure of the presence or absence of behaviours the researcher deemed to be supportive.

Second, this study has made a unique contribution to the literature regarding the construct of social support. Typically, social support has been considered a uni-dimensional construct. This study served to elucidate different and distinctive types of social support. Since these types of support showed differential relationships with the variables in this study, investigators researching social support would be remiss not to recognize this distinction and further explore the implications of different types of social support.

Third, this study utilized a measure of self-blame consisting of a variety of different items that explore many more aspects of the construct of self-blame than has been employed in previous research that has used only one question. Finally, this study contributes to the limited empirical literature that has sampled populations of child survivors of sexual abuse. By sampling a child population, this study has moved away from a reliance on retrospective accounts of adult survivors' perceptions of their childhood experiences.

Implications of the Present Findings

The findings of the present study lend preliminary support to Hindman's (1989) relationship model that describes the manner in which child survivors come to understand their abuse experience. Interestingly, the

distinction between the two constructs of social support (active vs. latent) becomes important when one looks to the variables that influence self-blaming attributions. Specifically, active social support, or what the survivor perceives she 'gets' in terms of support from the maternal caregiver seems to be more important in determining self-blame than her perceptions of latent support, or what she thinks her mother thinks of her. The opposite seems to hold true when the survivor is evaluating her relationship with the offender. That is, latent support from the offender seems to be more influential than active support in determining self-blame.

This reliance on the more latent form of support may be the survivor's way of dealing with the ambivalence that leads to the 'abuse dichotomy' as postulated by Briere (1992). Specifically, this may be a way for survivors to deal with ambivalence around knowing that the offender does not actively show support, yet still enables survivors to hold onto the belief that the offender does love and respect them. The result of this would be self-blame for the abuse. One implication of these findings is that careful attention should be paid to delineating the type of social support being investigated, both in research and treatment of survivors of sexual abuse.

Findings from this study have implications for treatment at both the assessment and planning levels and

implementation level. First, as recommended by Friedrich (1990), initial assessment is very useful in the planning of treatment with survivors of sexual abuse. Based on the findings of the present study, one important area to investigate in this assessment process is the survivors' perceptions of their social support networks. Since both maternal and offender support were found to be differentially related to levels of self-blame, this information could be helpful for clinicians in isolating specific treatment issues early in the treatment process.

In terms of Hindman's model, the best situation for the child immediately after disclosure would be to have a positive and supportive relationship with significant others. Hence, in the initial stages of treatment, it may be warranted to concentrate on building a supportive relationship between survivors and non-offending significant others before entering into areas concerning the survivor's perceptions/ambivalence toward the offender. By taking this approach, it may serve to decrease perceptions of self-blame and hence, decrease the impact of the abuse dichotomy.

Findings from this study also have implications for various treatment modalities. Further on in the treatment process, when strengthening of relationships with significant others is underway, there is a need in individual treatment to examine the implicit and/or explicit messages conveyed from therapist to survivor about the

offender. Caution may be warranted around linking the concepts of 'the abuse was not your fault' and 'the offender was wrong for doing this'. Each of these concepts should be therapeutically explored, yet these endeavours should be clearly delineated. One implication of the link between these ideas is that the opposite must also be true. Therefore, the survivor may be getting further entrenched in the 'abuse dichotomy'. If she feels that the offender values and respects her, she may feel that he would not do anything to harm her, therefore, the survivor may conclude more readily that she is to blame for the abuse. The separation of these issues should not be seen as a way to 'resolve' the survivors ambivalence, but to help her cope with the existence of it while not self-blaming.

Second, the findings of the present study lend support for the many treatment programmes that include a component, usually in the form of a support group, for non-offending significant others. Based on these results, it would be important for these groups to focus on developing active ways in which non-offending maternal caregivers can show support for their daughters. This may include teaching group members active listening skills, as well as teaching them to verbalize their support rather than assuming their daughter has knowledge of it.

The focus of these groups could also benefit from considering the finding that maternal support showed a

positive relationship to abuse-related support; in addition both types of support showed a relationship with attributional style. One conceptualization of these findings could be that survivors who feel that their mothers are particularly supportive around abuse-related issues have less negative attributional styles. Hence, since past research has shown a connection between self-deprecatory attributional styles and more severe negative symptomatology, mothers of survivors may be helpful in aiding their daughters to develop a more empowered view of the world. Therefore, it may be useful for non-offending mothers' groups to aid mothers in being openly supportive around issues related to the abuse experience. One such avenue may be to help mothers deal with any of their own ambivalence that they may be experiencing toward offenders and/or toward their daughters.

Third, although a controversial treatment modality (Friedrich, 1990), the findings from this study could be helpful in guiding family therapy with incestuous families. If this is the treatment modality chosen, issues around the relationships among perceptions of social support, type of social support, ambivalence, and self-blame can be directly teased apart and worked through. Direct interventions geared toward teaching family members helpful ways of supporting survivors could be implemented within a therapeutic context. Specifically, treatment could focus on

helping survivors provide immediate and direct feedback to non-offending parents regarding perceptions of helpful and not-so-helpful types of support. Further, if the offender is included in the family therapy, issues around ambivalence toward the offender, its relationship to social support, self-blame, and the 'abuse dichotomy' could be targeted as treatment foci. It must be explicitly stated that if the offender is included in this type of treatment plan, great consideration must be given to the appropriate time for this step. It would be critical for this introduction to take place under the following conditions: the survivor has adequately dealt with self-blaming issues, positive and supportive relationships between non-offending significant others and the survivor have been sufficiently established, and ensurance that the offender has made a commitment to therapy.

Directions for Future Research

Since the conclusions and implications of the present study are based on results that are on a sample of only 10 participants, additional support for this model needs to be garnered. Further research in this area is warranted by the encouraging preliminary results found here. A larger sample size would allow for the further investigation of the mediating role of social support in the assignment of self-blame. In addition, researchers need to more fully explore

the influence of the characteristics of the abuse experience on the perceptions of social support and self-blame. For example, past research has found a relationship between the use of coercion by intrafamilial offenders and greater distress experienced by survivors (Mennen, 1993). It would be interesting to further explore models that propose perceptions of social support coming from the offender as a mediating variable of this distress.

Moreover, research studies need to be conducted that more clearly delineate the relationships amongst social support, self-blame, and attributional style. For example, this study found relationships between social support and self-blame, social support and attributional style, and self-blame and attributional style, but it was beyond the scope of this study to examine the directionality of these relationships. Further exploration into this issue would be helpful in guiding treatment. An interesting approach for this endeavour would be qualitative research. Through this research paradigm, investigators would be able to more fully explore the psychological meanings of these constructs to survivors.

Studies utilizing various comparison groups, such as boys and girls, survivors of intra and extrafamilial abuse, and survivors of different ages would shed light on the similarities and differences amongst survivors of sexual abuse. Moreover, it would be interesting to compare groups

of survivors of sexual and physical abuse on variables such as social support and self-blame, to investigate questions of similar processes occurring across different types of abuse. Finally, children who have disclosed sexual abuse over the past 5 to 10 years represent the first generation of survivors to receive early treatment intervention specifically focused on their experiences of abuse (Briere, 1992). Hence there is a need in the area of sexual abuse research for longitudinal studies to be conducted in order to explore the course of symptomatology over time as well as the effects of these early intervention treatment programmes.

APPENDIX A

ABOUT THIS STUDY...

The purpose of this study is to help people who work with children who have been sexually abused figure out the best ways to help these children cope with, and understand, what has happened to them. This study is also being to done to help children and their families understand how their relationships can be helpful. This study is looking at protective factors that may help sexually abused children overcome some of the negative ways that they often feel.

Before the study can proceed, I will need to have you sign a form that says that you understand what the study is about and that you give permission for your daughter to participate. This form is a requirement from the University of Windsor, where I am working on my Master's degree, yet you can change your mind about allowing your daughter to participate at any time, even after the form has been signed.

In order to get at the information, this study is set up in two parts. First, the children will be asked questions about how they feel about different people in their lives, including their mothers, fathers, teachers, and friends. As well, they will be asked some questions about how they feel when good and bad things happen to them. These questions will be read to the children and it should take about 1 hour.

For the second part, the children's therapist/worker will be asked answer some questions about how the children feel about their experience of being sexually abused. The therapist/worker will not be asked to disclose any specific details of any therapy sessions. As well, the therapist/worker will be asked to provide some family background information.

Although these questions have been asked to many other children in similar studies, it is possible that answering the questions may remind your daughter of negative feelings. Participation in this study is completely voluntary. If for <u>any</u> reason you or your daughter do not wish to continue participating once the study is underway, you or she will be free to drop out at any time. The decision to participate or not to participate <u>will not</u> have any effect on any treatment that you and your daughter are currently receiving, or may be receiving in the future.

The paperwork for this study will be kept completely confidential. Your name and your daughter's name will never appear in any reports of this study. Your name and your daughter's name will also not appear on any of the answer

sheets, except the consent forms.

Once the study has been completed, you may receive a copy of the study results if you wish. All you have to do is tell your daughter's therapist or worker if you wish to receive this information.

If you agree to let your daughter participate in this study, please give her therapist/worker permission to let me give you a call, or you can call me at either of the numbers given below, as we will need set up a convenient time to meet in order to sign the Consent form and talk about the study.

If you have any questions about participating, please feel free to contact me directly at any time (258-9097 or 253-4232 Extension 2217).

Thank you for your cooperation.

APPENDIX B

Informed Consent-Parent Form

Purpose: People working with children who have been sexually abused are trying to figure out how they can help these children cope with what has happened to them. This study is looking at protective factors that may help them overcome some of the negative ways that sexually abused children often feel. This study is being to done to help children and their families understand how their relationships can be helpful. Therefore, this is a study about how children feel about different people in their lives, including their mothers, fathers, teachers, and friends. This study is also about how different children feel when good and bad things happen to them. This study is being done for a Master's thesis, in partial fulfilment of a Master of Arts degree in Child Clinical Psychology at the University of Windsor.

What participants do: If you agree to have your child participate in this study, she will be asked to answer some questions about the way she feels about different people in her life, such as her mother, father, teacher and friends, as well as how she thinks they feel about her. She will also be asked some questions about how she feels when good and bad things happen to her. This session with the researcher will last for approximately 1 1/2 hours. Finally, her therapist/worker will be asked to answer some questions about how your daughter feels about her experience of being sexually abused. The therapist/worker will not be asked to disclose any specific details of the therapy sessions. As well, the therapist/worker will be asked to provide some family background information.

Participants' rights: It is possible that answering the questions may remind your daughter of negative feelings. Your and her participation in this study is completely voluntary. If for any reason you or your daughter do not wish to continue participating once the study is underway, you or she will be free to drop out at any time. The decision to participate or not to participate will not have any effect on any treatment that you and your daughter are currently receiving, or may be receiving in the future. The paperwork for this study will be kept completely confidential. Your name and your daughter's name will never appear in any reports of this study. Your name and your daughter's name will also not appear on any of the answer sheets, except this consent form and her consent form. Since your or your daughter's name will not be on any of the information collected, it will not be possible to

identify any of it for use in any court of law as a victim witness impact statement. You or your daughter may ask questions about the procedure of this study at any time, and your and her questions will be answered.

Feedback: Once the study has been completed, you may receive a copy of the study results if you wish. Please tell your daughter's therapist or worker if you wish to receive this information and I will arrange to get a copy of the results to her or him and they will send it to you.

I understand that this research project has been cleared by the Ethics Committee of the Psychology Department at the University of Windsor. Any concerns about the procedure may be reported to the chairperson of the Department of Psychology Ethics Committee at the University of Windsor (Chairperson: Dr. Ron Frisch, 253-4232, Extension 7012).

If you have any questions about participating, please feel free to contact me, or my thesis supervisor, Dr. Julie Hakim-Larson, directly at any time. Thank you for your cooperation.

Julie Hakim-Larson, Ph. D.
University of Windsor
Department of Psychology
(519) 253-4232, Extension 2241

Linda Reinstein, B.A. Hons.
University of Windsor
Department of Psychology
(519) 253-4232, Extension 2217

I, _____ (please print name), HAVE READ THIS CONSENT FORM AND AGREE TO ALLOW MY DAUGHTER, _____ (please print name) TO PARTICIPATE.

Signature of parent/guardian _____

Date _____

Informed Consent-Parent Form (R.C.C.)

Purpose: People working with children who have been sexually abused are trying to figure out how they can help these children cope with what has happened to them. This study is looking at protective factors that may help them overcome some of the negative ways that sexually abused children often feel. This study is being to done to help children and their families understand how their relationships can be helpful. Therefore, this is a study about how children feel about different people in their lives, including their mothers, fathers, teachers, and friends. This study is also about how different children feel when good and bad things happen to them. This study is being done for a Master's thesis, in partial fulfilment of a Master of Arts degree in Child Clinical Psychology at the University of Windsor.

What participants do: If you agree to have your child participate in this study, she will be asked to answer some questions about the way she feels about different people in her life, such as her mother, father, teacher and friends, as well as how she thinks they feel about her. She will also be asked some questions about how she feels when good and bad things happen to her. This session with the researcher will last for approximately 1 1/2 hours. Finally, her therapist/worker will be asked to answer some questions about how your daughter feels about her experience of being sexually abused. The therapist/worker will not be asked to disclose any specific details of the therapy sessions. As well, the therapist/worker will be asked to provide some family background information.

Participants' rights: It is possible that answering the questions may remind your daughter of negative feelings (e.g., sad, anxious). Your and her participation in this study is completely voluntary. If for any reason you or your daughter do not wish to continue participating once the study is underway, you or she will be free to drop out at any time. To do this you can contact your Case Manager or the Co-ordinator of Clinical Records at the Regional Children's Centre at (519) 257-5215. The decision to participate or not to participate will not have any effect on any treatment that you and your daughter are currently receiving at Regional Children's Centre or may be receiving in the future. The paperwork for this study will be kept completely confidential. Your name and your daughter's name will never appear in any reports of this study. Your name and your daughter's name will also not appear

on any of the answer sheets, except this consent form and her consent form. Since your or your daughter's name will not be on any of the information collected, it will not be possible to identify any of it for use in any court of law as a victim witness impact statement. You or your daughter may ask questions about the procedure of this study at any time, and your and her questions will be answered.

Feedback: Once the study has been completed, you may receive a copy of the study results if you wish. Please tell your daughter's therapist or worker if you wish to receive this information and I will arrange to get a copy of the results to her or him and they will send it to you.

I understand that this research project has been reviewed by the Ethics Committee of the Psychology Department at the University of Windsor and by the Regional Children's Centre Research Evaluation Committee. Any concerns about the procedure may be reported to your case manager at the Regional Children's Centre and/or the Co-ordinator of Clinical Records at the Regional Children's Centre (257-5215), who will refer the complaint to the Regional Children's Centre Management Group. The concerns may also be reported to the chairperson of the Department of Psychology Ethics Committee at the University of Windsor (Chairperson: Dr. Ron Frisch, 253-4232, Extension 7012).

If you have any questions about participating, please feel free to contact your case manager, me, or my thesis supervisor, Dr. Julie Hakim-Larson, directly at any time. Thank you for your cooperation.

Julie Hakim-Larson, Ph. D.
University of Windsor
Department of Psychology
(519) 253-4232, Extension 2241

Linda Reinstein, B.A. Hons.
University of Windsor
Department of Psychology
(519) 253-4232, Extension 2217

I, _____ (please print name), HAVE READ THIS CONSENT FORM AND AGREE TO ALLOW MY DAUGHTER, _____ (please print name) TO PARTICIPATE.

Signature of parent/guardian _____

Witness _____

Date _____

APPENDIX C

Informed Assent-Child Form

Purpose: This is a study about how children feel about different people in their lives, including their mothers, fathers, teachers, and friends. This study is also about how different children feel when good and bad things happen to them.

What participants do: If you agree to participate in this study, you will be asked to answer some questions about the way you feel about different people in your life, such as your mother, father, teacher and friends, as well as how you think they feel about you. You will also be asked some questions about how you feel when good and bad things happen to you. This session with me, the researcher, will take about 1 1/2 hours.

Participants' rights: It is possible that answering the questions may remind you of bad feelings. Your participation in this study is completely voluntary. If for any reason you do not wish to continue participating once the study has started, you will be free to stop at any time. The decision to participate or not to participate will not have any effect on what you are doing with your therapist or worker. The paperwork for this study will be kept completely confidential. That means that your name will never appear in any reports of this study. Your name will also not appear on any of the answer sheets, except this consent form. You may ask questions about what we are doing at any time, and your questions will be answered.

I know that, if I agree to participate in this study, I will be answering some questions about myself that have been explained to me. It will take about one and a half hours to finish.
I am volunteering to do this, and my mom has given permission to let me participate. I am allowed to stop participating whenever I want to, and can refuse to answer any questions. No one will be told about my answers.

I, _____ (please print your name on the line), HAVE READ THIS CONSENT FORM AND AGREE TO PARTICIPATE IN THIS STUDY.

Signature _____

Date _____

Informed Assent-Child Form (R.C.C.)

Purpose: This is a study about how children feel about different people in their lives, including their mothers, fathers, teachers, and friends. This study is also about how different children feel when good and bad things happen to them.

What participants do: If you agree to participate in this study, you will be asked to answer some questions about the way you feel about different people in your life, such as your mother, father, teacher and friends, as well as how you think they feel about you. You will also be asked some questions about how you feel when good and bad things happen to you. This session with me, the researcher, will take about 1 1/2 hours.

Participants' rights: It is possible that answering the questions may remind you of bad feelings. Your participation in this study is completely voluntary. If for any reason you do not wish to continue participating once the study has started, you will be free to stop at any time. The decision to participate or not to participate will not have any effect on what you are doing with your therapist or worker at the Regional Children's Centre. The paperwork for this study will be kept completely confidential. That means that your name will never appear in any reports of this study. Your name will also not appear on any of the answer sheets, except this consent form. You may ask questions about what we are doing at any time, and your questions will be answered.

I know that, if I agree to participate in this study, I will be answering some questions about myself that have been explained to me. It will take about one and a half hours to finish.

I am volunteering to do this, and my mom has given permission to let me participate. I am allowed to stop participating whenever I want to, and can refuse to answer any questions. No one will be told about my answers.

I, _____ (please print your name on the line), HAVE READ THIS CONSENT FORM AND AGREE TO PARTICIPATE IN THIS STUDY.

Signature _____

Witness _____

Date _____

APPENDIX D

Debriefing...for child participants

I want to thank you for letting me ask you these questions.

Your answers, along with answers from other kids who are also doing this, could be really helpful for people who work with kids and families who have gone through similar experiences.

1. Now it's your turn to ask me questions -- Do you have any questions that you can think of about what we've just done that you'd like to ask me?

2. Now that we're finished, how are you feeling right now? (If participant responds that she is not feeling O.K. after our session -- It's really important for you to talk to (primary service provider/therapist) about this and how you are feeling. So what I want you to do is, the next time you see her/him, to let them know and talk about it more with them.)

3. If you do have any questions that you think of after you leave, maybe tonight, tomorrow, even in a week or in a month, It's important that you get answers to them. So what I want you to do is ask (primary service provider/therapist) any questions you have. If they can't answer them for you, they will call me and I will get you an answer for your next meeting with them.

4. Some kids find it a little hard sometimes to answer these kinds of questions, and I want to tell you that you did a great job and really helped me out. Thank you very much.

REFERENCES

Bagley, C. (1991). The long-term psychological effects of child sexual abuse: A review of some British and Canadian studies of victims and their families. Annals of Sex Research, 4, 23-48.

Beck, A. T. (1972). Depression: Causes and treatment. Philadelphia, PA: University of Pennsylvania Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emory, G. (1979). Cognitive therapy of depression. New York: Guilford.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G., Akman, D. (1991). A review of the short-term effect of child sexual abuse. Child Abuse and Neglect, 15, 537-556.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. Child Abuse and Neglect, 16, 101-118.

Berliner, L. (1987). Treating the effects of sexual abuse on children. Journal of Interpersonal Violence, 2, 415-434.

Bifuco, A., Brown, G. W., & Adler, Z. (1991). Early sexual abuse and clinical depression on adult life. Journal of Psychiatry, 159, 115-122.

Conte, J. R. (1987). Factors associated with an increased impact of child sexual abuse. Child Abuse and Neglect, 11, 201-211.

DeYoung, M. (1982). Sexual victimization of children. Jefferson, NC: McFarland.

DeYoung, M., & Lowry, J. (1992). Traumatic bonding: Clinical implications in incest. Child Welfare, 71, 165-173.

Everson, M. D., Hunter, W. M., Runyon, D. K., Edelsohn, G. A., & Coulter, M. L. (1989). Maternal support following disclosure of incest. American Journal of Orthopsychiatry, 59, 197-207.

Finkelhor, D. (1984). Child sexual abuse. New York: Free Press.

Finkelhor, D. (1990). Early and long-term effects of childhood sexual abuse: An update. Professional Psychology: Research and Practice, 21, 325-330.

Finkelhor, D., & Baron, L. (1986). Risk factors for child sexual abuse. Journal of Interpersonal Violence, 1, 43-71.

Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. Child Abuse and Neglect, 14, 19-28.

Friedrich, W. N. (1990). Psychotherapy of sexually abused children and their families. New York: W. W. Norton & Company.

Geffner, R. (1992). Current issues and future directions in child sexual abuse. Journal of Child Sexual Abuse, 1, 1-11.

Gentile, C., Wolfe, V., & Wolfe, D. (1988). Factors mediating the impact of sexual maltreatment on children: Attributional style and severity of the abuse. Poster presented at the Conference of the Canadian Psychological Association, June 1988, Montreal, Quebec.

Gibbons, J. D. (1971). Nonparametric statistical inference. New York: McGraw-Hill.

Gibbons, J. D. (1976). Nonparametric methods for quantitative analysis. New York: Holt, Rinehart, and Winston.

Gold, E. R. (1986). Long-term effects of sexual victimization on childhood: An attributional approach. Journal of Consulting and Clinical Psychology, 54, 471-475.

Gorcey, M., Santiago, J. M., & McCall-Perez, F. (1986). Psychological consequences for women sexually abused in childhood. Social Psychiatry, 21, 129-133.

Harter, S. (1985). The social support scale for children and adolescents. Denver, CO: University of Denver.

Harter, S., Marold, D. B., Whitesell, N. R. (1992). Model of psychosocial risk factors leading to suicidal ideation in young adolescents. Development and Psychopathology, 4, 167-188.

Harter, S., & Nowakowski, M. (1987). Dimensions of depression profile for children and adolescents. Denver, CO: University of Denver.

Harvey, D. M. (1981). Depression and attribution style: Interpretations of important personal events. Journal of Abnormal Psychology, 90, 134-142.

Hetherington, E. M., & Parke, R. D. (1986). Child psychology: A contemporary viewpoint. New York: McGraw-Hill.

Hindman, J. (1989). Just before dawn: From the shadows of tradition to new reflections in trauma assessment and treatment of sexual victimization. Ontario, OR: AlexAndria Associates.

Hoagwood, K. (1990). Blame and adjustment among women sexually abused as children. Women and Therapy, 9, 89-110.

Hunter, J. A., Goodwin, D. W., & Wilson, R. J. (1992). Attributions of blame in child sexual abuse victims: An analysis of age and gender influences. Journal of Child Sexual Abuse, 1, 75-89.

James, B. (1989). Treating traumatizing children: New insights and creative interventions. Lexington, MA: Lexington Books.

Janoff-Bulman, R. (1979). Characterological versus behavioral self-blame: Inquiries into depression and rape. Journal of Personality and Social Psychology, 37, 1798-1809.

Janoff-Bulman, R. (1983). A theoretical perspective for understanding reactions to victimization. Journal of Social Issues, 39, 1-17.

Jehu, D. (1989). Mood disturbances among women clients sexually abused in childhood. Journal of Interpersonal Violence, 4, 164-184.

Kaslow, N. J., Tannenbaum, R. L., & Seligman, M. E. P. (1978). The KASTAN: A children's attributional style questionnaire. Unpublished manuscript, University of Pennsylvania, PA.

Kendall-Tackett, K. A., Williams, L. M., Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113, 164-180.

Kuiper, N. A. (1978). Depression and causal attribution for success and failure. Journal of Personality and Social Psychology, 36, 236-246.

Mannarino, A. P., Cohen, J. A., & Gregor, M. (1989). Emotional and behavioral difficulties in sexually abused girls. Journal of Interpersonal Violence, 4, 437-451.

McClelland, L., Mynors-Wallis, L., Fahy, T., & Treasure, J. (1991). Sexual abuse, disordered personality and eating disorders. British Journal of Psychiatry, 158, 63-68.

McGarry, M. S. (1987). Sexual abuse and power dynamics: Learned helplessness in adolescent victims. Dissertations Abstracts International, 49, 916B.

Mennen, F. E. (1993). Evaluation of risk factors in childhood sexual abuse. Journal of American Academy of Child and Adolescent Psychiatry, 32, 934-939.

Morrow, K. B., & Sorell, G. T. (1989). Factors affecting self-esteem, depression, and negative behaviors in sexually abused female adolescents. Journal of Marriage and Family, 51, 677-686.

Ney, P. G., Moore, C., McPhee, M., Trought, P. (1986). Child abuse: A study of the child's perspective. Child Abuse and Neglect, 10, 511-518.

Novak, P. G. (1993). The children's impact of traumatic events scale-revised: Confirming factor structure. Unpublished senior honours thesis, University of Western Ontario, London, Ontario.

Riggs, J. M. (1985). Review of self perception inventory. In J. V. Mitchell, (Ed.). The ninth mental measurements yearbook (pp.1350-1351). Lincoln, NB: University of Nebraska Press.

Rew, L. (1989). Childhood sexual exploitation: Long-term effects among a group of nursing students. Issues in Mental Health Nursing, 10, 181-191.

Rutter, M. (1989). Isle of Wight revisited: Twenty-five years of chid psychiatric epidemiology. Journal of the American Academy of Child Adolescent Psychiatry, 28, 633-653.

Root, M. P. P., & Fallon, P. (1988). The incidence of victimization experiences in a bulimic sample. Journal of Interpersonal Violence, 3, 161-173.

Seligman, M. E. P., Abramson, L. Y., Semmel, A., & Von Baeyer, C. (1979). Depressive attributional style. Journal of Abnormal Psychology, 88, 242-247.

Seligman, M. E. P., Peterson, C., Kaslow, N. J., Tannenbaum, R. L., Alloy, L. B., & Abramson, L. Y. (1984). Attributional style and depressive symptoms among children. Journal of Abnormal Psychology, 93, 235-238.

Shapiro, J. P. (1987). Self-mutilation and self-blame in incest victims. American Journal of Psychotherapy, 41, 46-54.

Shapiro, J. P. (1989). Self-blame versus helplessness in sexually abused children: An attributional analysis with treatment recommendations. Journal of Social And Clinical Psychology, 8, 442-455.

Shapiro, J. P., Leifer, M., Martone, M. W., & Kassem, L. (1992). Cognitive functioning and social competence as predictors of maladjustment in sexually abused girls. Journal of Interpersonal Violence, 7, 156-164.

Siegel, S., & Castellan, N. J., Jr. (1988). Nonparametric statistics for the behavioral sciences (2nd ed.). New York: McGraw Hill.

Soares, A. T., & Soares, L. M. (1975). The self perception inventory. Trumbull, CT.: Soares Associates.

Sroufe, L. A., & Rutter, M. (1985). The domain of developmental psychopathology. Child Development, 55, 17-29.

Stern, G. W. (1989). The effect of childhood sexual abuse on adult attributional styles. Dissertation Abstracts, 51, 1007B.

Tsai, M., & Wagner N. (1978). Therapy groups for women sexually molested as children. Archives of Sexual Behavior, 7, 417-421.

Wolfe, V., & Gentile, C. (1991). Children's impact of traumatic events scale-revised. Unpublished manuscript, Children's Hospital of Western Ontario, London, Ontario.

Wolfe, V., Gentile, C., & Bourdeau, P. (1986). History of victimization form. Unpublished manuscript, Children's Hospital of Western Ontario, London, Ontario.

Wolfe, V., Gentile, C., Michienzi, T., Sas, L., Wolfe, D. A. (1991). The children's impact of traumatic events scale: A measure of post-sexual-abuse PTSD symptoms. Behavioral Assessment, 13, 359-383.

Wyatt, G. E., & Newcomb, M. (1990). Internal and external mediators of women's sexual abuse in childhood. Journal of Consulting and Clinical Psychology, 58, 758-767.

VITA AUCTORIS

Linda Reinstein was born on May 24, 1968, in Toronto, Ontario. In 1987 she graduated from Forest Hill Collegiate Institute in Toronto. She received an Honours B.A. in Psychology at McGill University in 1991. Since 1992, she has been enrolled in the doctoral programme in child clinical psychology at the University of Windsor.